

HEALTH OBJECTIVES 2000 ACT

HEARING
BEFORE THE
COMMITTEE ON
LABOR AND HUMAN RESOURCES
UNITED STATES SENATE
ONE HUNDRED FIRST CONGRESS
SECOND SESSION

ON
S. 2056

TO AMEND TITLE XIX OF THE PUBLIC HEALTH SERVICE ACT TO PROVIDE GRANTS TO STATES TO ESTABLISH AND IMPLEMENT STATE HEALTH OBJECTIVES PLANS, AND FOR OTHER PURPOSES.

APRIL 20, 1990

Printed for the use of the Committee on Labor and Human Resources



U.S. GOVERNMENT PRINTING OFFICE

33-862

WASHINGTON : 1990

For sale by the Superintendent of Documents, Congressional Sales Office
U.S. Government Printing Office, Washington, DC 20402

5541-57

COMMITTEE ON LABOR AND HUMAN RESOURCES

EDWARD M. KENNEDY, Massachusetts, *Chairman*

CLAIBORNE PELL, Rhode Island
HOWARD M. METZENBAUM, Ohio
CHRISTOPHER J. DODD, Connecticut
PAUL SIMON, Illinois
TOM HARKIN, Iowa
BROCK ADAMS, Washington
BARBARA A. MIKULSKI, Maryland
JEFF BINGAMAN, New Mexico

ORRIN G. HATCH, Utah
NANCY LANDON KASSEBAUM, Kansas
JIM JEFFORDS, Vermont
DAN COATS, Indiana
STROM THURMOND, South Carolina
DAVE DURENBERGER, Minnesota
THAD COCHRAN, Mississippi

NICK LITTLEFIELD, *Staff Director and Chief Counsel*
KRISTINE A. IVERSON, *Minority Staff Director*

CONTENTS

STATEMENTS

FRIDAY, APRIL 20, 1990

	Page
Harkin, Hon. Tom, a U.S. Senator from the State of Iowa, prepared statement	3
Pell, Hon. Claiborne, a U.S. Senator from the State of Rhode Island, prepared statement	6
Hatch, Hon. Orrin G., a U.S. Senator from the State of Utah, prepared statement	7
McGinnis, J. Michael, M.D., Deputy Assistant Secretary for Health, Disease Prevention and Health Promotion, U.S. Department of Health and Human Services	8
Prepared statement	15
Brooks, Rev. John H., and Ramona J., Congregational United Church of Christ, Rock Rapids, IA; Herrestine Chambers, Belzoni, MS, Program for Improved Nutrition and Health, Greenwood, MS; and Emily Holing and Erin Holing, Bellevue, WA	28
Prepared statements of:	
Mrs. Brooks	31
Rev. Brooks	32
Ms. Holing	40
Fox, Earl, M.D., director of health, Alabama, and member, Association of State and Territorial Health Officials (ASTHO); C. William Keck, M.D., M.P.H., president-elect, American Public Health Association (APHA), and director, Department of Health, Akron, OH; Suzanne Muncy, National Association of County Health Officials, and deputy director of health, Montgomery County; and Jane Delgado, Ph.D., president, National Coalition of Hispanic Health and Human Services Organizations (COSSMHO)	46
Prepared statements of:	
Dr. Scott (with attachments)	50
Dr. Keck	68
Ms. Delgado	78
Wasserman, Martin P., M.D., president, National Association of County Health Officials, prepared statement	74
Partners for Improved Nutrition and Health (PINAH), prepared statement	91
Bowdish, Joyce, R.N., Family and Community Health, State of Iowa, prepared statement	95
Schadle, Jane Cameron, R.N., Des Moines, IA, prepared statement	97
Kirsch, Lawrence, Whittamore, IA, prepared statement	97

(III)

HEALTH OBJECTIVES 2000 ACT

FRIDAY, APRIL 20, 1990

U.S. SENATE,
COMMITTEE ON LABOR AND HUMAN RESOURCES,
Washington, DC.

The committee met, pursuant to notice, at 10:04 a.m., in room SD-430, Dirksen Senate Office Building, Senator Tom Harkin presiding.

Present: Senators Pell, Harkin, and Cochran.

OPENING STATEMENT OF SENATOR HARKIN

Senator HARKIN. The Committee on Labor and Human Resources will come to order.

We are meeting today to review the Health Objectives 2000 Act. American health care—its quality, availability, and cost—are of great concern to all of us. The Health Objectives 2000 Act will help us plan for a healthier future. It puts into practice my belief that we can save lives and money by taking a common sense approach in our health care system.

I want to thank those who have joined with me in support of this effort, in particular Senator Kennedy, the chairman. No one has worked harder to protect the health of Americans than Senator Kennedy. I also want to thank Senator Hatch, the ranking member of the committee, and Senator Pell, both of whom have been champions of health promotion and disease prevention for many years.

The Health Objectives 2000 Act will implement the National Health Objectives for the year 2000. These objectives are measurable targets, such as reducing infant mortality or lowering the risks for contracting cancer, that will improve the health of the Nation. They represent the input of more than 300 national membership organizations and all the State and territorial health departments, some 7,000 people in all. They will be published in final form in September of this year.

The national health objectives are a follow-up to a previous effort—the 1990 health objectives. The 1990 objectives pointed the way for many improvements. However, gains have not been universal. Many of the new objectives will aim specifically at improving the health status of certain groups of people who seem to bear a disproportionate share of disease, disability, and premature death compared to the general population.

The Health Objectives 2000 Act also offers an opportunity for improving the quality of our information and developing better methodology for attacking the problems that attack our health. We

know a lot about the outcomes that result in death, but not as much about the outcomes that result in disability. We need to know more about how environmental noise affects hearing loss, for example.

The bill provides funding to designated official State public health agencies based upon State plan target objectives which are consistent with the act and yet tailored to States' needs. States will be able to use funds for programs that target improved health status such as reducing injury or increasing years of healthy life. In addition, funds are designated for the professional training of public health personnel and to provide assistance for research and for pilot and demonstration projects. States are encouraged to form partnerships with Federal, State, and local health groups in agencies, voluntary health organizations, and other health groups in order to develop initiatives that are set out in the State plan.

An advisory committee will be established by the Secretary of the Department of Health and Human Services, known as the National Health Objectives Advisory Committee, to advise regarding national health priorities.

The act authorized \$300 million for fiscal year 1991, with 90 percent of the appropriated amounts to be used for allotments to designated official State public health agencies.

I am very concerned that, as a Nation, we review and renew our commitment to our public health goals. It should concern all of us that we spent \$680 billion a year on health care in America, with only a very small percentage going to treat rather than prevent disease disability. If we were to save even 1 percent of that \$680 billion each year, we could save \$6.8 billion a year.

There are many examples of how we can save money through good health promotion and disease prevention programs. The chart up here indicates that. For prenatal care, for example, if we spent \$600 to provide prenatal care for a woman who is pregnant, we are better able to prevent her child from being born prematurely with a low birth weight. The cost of a premature baby can go as high as \$500,000. That is what the cost would be. So with \$600, we would save \$500,000. The cost of a Pap smear is \$11. However, treating late stage cervical cancer, the cost is well over \$13,000. Colorectal cancer screening cost is \$200; \$13,000 is the cost of treating colorectal cancer. Blood pressure test, \$5, yet it costs \$30,000 for one heart bypass surgery. So you can see that for a small amount of money invested, we can save a lot later on.

The second chart that I have up there also shows how we save money. I think businesses are learning that developing health promotion and fitness programs save them money. A health work force helps us to be competitive in a global marketplace. It saves millions of dollars in health care costs. The Health Insurance Association of America estimates that business can save \$6 in medical costs for every dollar spent on prevention.

This is an example from the Canada Life Assurance Company. They developed a pilot fitness and health promotion program. They enrolled 20 percent of their employee; 240 employees participated in this health promotion program. In the first year of the operation, the company estimated they had saved \$37,000 in health care costs alone.

However, beyond that, they reduced their absenteeism rate by 22 percent, and that along with the reduced employee turnover saved them another \$231,000. That was just for the first year. So it works, and I think businesses are beginning to understand that the few dollars that they would put into health care promotion and prevention saves them a bundle of money later on.

[The prepared statement of Senator Harkin follows:]

PREPARED STATEMENT OF SENATOR HARKIN

Senator HARKIN. The Committee on Labor and Human Resources is meeting today to review the Health Objectives 2000 Act. American health care—its quality, availability, and cost—are of great concern to all of us. The Health Objectives 2000 Act will help us plan for a healthier future. It puts into practice my belief that we can save lives and save money by taking a common sense approach in our health care system.

I want to thank those who have joined me in support of this effort. In particular, I want to commend our Chairman, Senator Kennedy. No one has worked harder to protect the health of Americans than Senator Kennedy. Also I want to thank Senator Hatch, the Ranking member of the committee, and Senator Pell both of whom have been champions of health promotion and disease prevention for many years.

The Health Objectives 2000 Act will implement the National health Promotion and Disease Prevention Objects for the Year 2000. These objectives are measurable targets, such as reducing infant mortality or lowering the risks for contracting cancer, that will improve the health of the Nation. They represent the input of more than 300 national membership organizations and all the State and territorial health departments, some 7,000 people in all. They will be published in final form in September of this year.

The National Prevention Objectives are a follow-up to a previous effort—the 1990 health objectives. The 1990 objectives pointed the way for many improvements. However, gains have not been universal. Many of the new objectives will aim specifically at improving the health status of certain groups of people who seem to bear a disproportionate share of disease, disability and premature death compared to the general population.

The Health objectives 2000 Act also offers an opportunity for improving the quality of our information and developing better methodology for attacking the problems that assail our health. We know a lot about the outcomes that result in death, but not as much about the outcomes that result in disability. We need to know more about how environmental noise affects hearing loss, for example. We know how many children die from drowning, but we don't know how many children there are who are substantially disabled as a result of near drowning.

The bill provides funding to designated official State public health agencies, based upon State plan target objectives which are consistent with the Year 2000 Objectives and yet tailored to State needs. States will be able to use funds for programs that target improved health status such as reducing injury, or increasing years of healthy life. In addition funds are designated for the professional

training of public health personnel and to provide assistance for research, and for pilot and demonstration projects. States are encouraged to form partnerships with Federal, State, and local health agencies, voluntary health organizations, and other health groups in order to develop initiatives that are set out in the State plan.

An advisory committee will be established by the Secretary of the Department of Health and Human Services, known as the national Health objectives Advisory Committee, to advise regarding national health priorities.

The act authorizes \$300 million for fiscal year 1991, with 90 percent of appropriated amounts to be used for allotments to designated official State public health agencies. The Preventive Block Grant Program becomes part of this act, at the time it is due to be reauthorized, on October 1, 1992.

I see a shift beginning in this country—toward health and wellness, in contrast to focusing most of our attention on illness. Americans are interested in being healthy and staying fit. The Health Objectives 2000 Act will help make Americans get healthier by expanding the base of support for wellness and prevention efforts. It will provide the opportunity to build new programs, and supplement the array of important categorical programs which are an essential component of ongoing public health efforts. We must also continue to protect and expand our categorical programs.

While we have made progress, we still have a lot to do. Recently, I directed the Senate Labor Committee staff to survey eight midwestern States, including my own State of Iowa, and ask them how they were doing on five health status measures. In addition to Iowa, South Dakota, Minnesota, Wisconsin, Nebraska, Kansas, Missouri, and Illinois were included. We selected measures that would capture information about Americans of all ages, such as the number of low birth weight babies born and the number of deaths related to cancer and stroke.

Despite improvements over the last 10 years, midwestern States are faring worse than the national average when it comes to killers such as cancer and stroke. These killers can be prevented. Screening programs and life style changes are proven strategies. We can do more to ensure the health and vitality of our senior citizens and reduce their risk of contracting these deadly diseases.

The good news is that these same States report better than average success in reducing the number of low birth weight babies—those born weighing less than 2,500 grams. Nationally, 6.8 percent of all live births are babies born weighing less than 2,500 grams. Iowa and Minnesota report rates of 5.1 percent and 5 percent, which is target objective for the Nation for the Year 2000.

We know how to promote health. We need the will to do it.

I am very concerned that, as a nation, we review and renew our commitment to our public health goals. It concerns me that we spend more than a half-trillion dollars on health care in America with all but 3 percent going to treat rather than prevent disease and disability. If we were to save even 1 percent of the \$680 billion per year that Americans spend on health care, we could save \$6.8 billion per year.

Let me give you some examples of how we can save money through good health promotion and disease prevention programs. If

we spend \$600 to provide prenatal care to a woman who is pregnant, we are better able to prevent her child from being born prematurely. The cost of a premature baby can go as high as \$500,000 as you can see on the chart. So we can spend \$600 in order to save \$500,000.

Here are some other examples. The cost of a pap smear is \$11 as compared to the cost of treating late stage cervical cancer which is over \$13,000.

The cost of screening for colorectal cancer is \$200. It costs approximately \$13,000 to treat colorectal cancer.

To give a blood pressure test costs \$5. To have heart bypass surgery costs \$30,000 or more.

Materials needed to educate someone about the importance of using a motorcycle or bicycle helmet cost as little as \$10. That small expenditure can save up to \$4.5 million, the estimated lifetime cost of a severe head injury.

And this does not even estimate the value of improved quality of life for people whose babies are born healthy, who do not develop cancer, do not experience a head injury, or have to have heart surgery.

Business is learning about developing health promotion and fitness programs in order to save money. A healthy workforce helps America remain competitive in global marketplace as well as save millions of dollars in health care costs. The Health Insurance Association of America estimates that business can save \$6 in medical costs for every \$1 spent on prevention.

Here is an example—and it is displayed on the chart. The Canada Life Assurance Company developed a pilot fitness and health promotion program and enrolled 20 percent of their employees—240 employees were enrolled. In its first year of operation, the company estimated they had saved \$37,000 in health care costs alone.

They also reduced their absenteeism rate by 22 percent and that, along with reduced employee turnover, saved them another \$231,000. And that is just in 1 year.

We have a number of witnesses today who will tell us about the importance of health promotion and disease prevention from both a personal and a policy perspective. Our first witness is Dr. Michael McGinnis, the Director of the Office of Health Promotion and Disease Prevention. Dr. McGinnis and his staff are working to finalize the National Health Objectives for the Year 2000 to be published in September.

So that sets the stage for the hearing today. We have a number of witnesses who will tell us about the importance of health promotion and disease prevention, from both a personal and policy perspective. We basically have three panels. The first panel is Dr. Michael McGinnis, the director of the Office of Health Promotion and Disease Prevention in the Secretary's office. The second panel will be some consumers, and the third panel will represent different organizations.

First, Dr. McGinnis and his staff are working to finalize the national health objectives for the year 2000, which, as I understand, will be published in September of this year. Dr. McGinnis has a

long and distinguished record and history in the field of health promotion and disease prevention. We are delighted he is here.

Before we turn to Dr. McGinnis, I would again recognize another distinguished member of this panel, someone who, again, has been in the forefront of the fight for health promotion and disease prevention for a long time, Senator Pell.

OPENING STATEMENT OF SENATOR PELL

Senator PELL. Thank you very much, Mr. Chairman, and thank you for holding this hearing. I was very happy, very glad to join with you and Senator Hatch in introducing this legislation, and very glad that so many of our own colleagues on the committee are among the 26 bipartisan cosponsors joined in support of this bill.

We join together to introduce this legislation because we share a belief in the words of Halliburton: "An ounce of prevention is worth a pound of cure." As youngsters, we were taught this by our parents through such simple things as brushing our teeth or eating vegetables, etc, etc. Halliburton's observation was true then, Mr. Chairman, and it is true today. People of our Nation yearn for information about health, nutrition, and physical and mental well-being.

What we have not done, Mr. Chairman, is to incorporate this sound thinking about prevention into our health agenda. We have not yet devoted our efforts or our resources to making health promotion and disease prevention an integral part of our Federal public health effort. So I am very glad that we are holding this hearing and would ask that the balance of my statement be inserted in the record as if read.

[The prepared statements of Senator Pell and Senator Hatch follow:]

PREPARED STATEMENT OF SENATOR PELL

Senator PELL. Thank you very much, Mr. Chairman, for holding today's hearing on the Health Objectives 2000 Act. I was delighted to join with you and Senator Hatch in introducing this very important health legislation. I am also quite pleased that so many of our colleagues on this committee are among the 26 bipartisan cosponsors who have already joined in support of this bill.

Mr. Chairman, we joined together to introduce this legislation because we share a belief in the words of T. C. Haliburton: "An ounce of prevention is worth a pound of cure." As youngsters, many of us were taught this by our parents, who were seeking a way perhaps, to persuade us to brush our teeth, eat our vegetables, or visit our doctor.

Haliburton's observation was true then, Mr. chairman, and it is true today. The people of this Nation yearn for information about health, nutrition, and physical and mental well-being. They understand that today, we know a great deal about how to promote good health, prevent disease, and enhance the quality and length of life.

What we have not done, Mr. chairman, is to incorporate this sound thinking about prevention into our national health agenda. We have not yet devoted our efforts or our resources to making

health promotion and disease prevention an integral part of our Federal public health effort.

The Health Objectives 2000 legislation is a first and major step toward changing this situation. It is comprehensive legislation to help implement programs in our States and cities to achieve important health goals identified by our Nation's public health leaders. It is a legislative beginning to ensuring that preventing disease becomes as important as curing disease.

Mr. Chairman, I must add how very concerned and sorry I am that serious illness has prevented Dr. H. Denman Scott, current president of the Association of State and Territorial Health Officials and director of health for my own State of Rhode Island, from testifying today. I am sure my colleagues on the committee will join me in wishing Dr. Scott a speedy and complete recovery. I would also like to thank Dr. Earl Fox, a member of the ASTHO executive board and director of health for the State of Alabama, for coming to Washington on such short notice to deliver Dr. Scott's testimony to us.

I look forward to hearing the testimony of today's witnesses and thank you, Mr. chairman, for your leadership in this important health area and for your partnership and great cooperation on this particular legislation.

PREPARED STATEMENT OF SENATOR HATCH

Senator HATCH. Today, we have the knowledge to become a healthier society.

We have learned that immunizations can guard the lives of infants against childhood diseases. Deaths and complications from diphtheria, whooping cough, and polio have been greatly decreased.

We have learned that smoking is responsible for nearly a third of all deaths that occur as a result of cancer, cardiovascular, and pulmonary disease. And, our efforts to stop smoking or to prevent Americans from every smoking are working. The percentage of adults who smoke has steadily declined along with death rates from illnesses associated with smoking.

We have learned that injuries are the leading cause of death for people between the ages of 4 and 44 years of age. Motor vehicle accidents are responsible for a majority of these injuries, and they can be reduced by wearing seat belts, driving only when sober, and reducing speeds.

These are examples of disease prevention and health promotion efforts that have worked. I am pleased that this hearing is being held today on the Health objectives 2000 Act. It gives us an opportunity to highlight an important goal in health policy—health promotion and disease prevention. Through health promotion and disease prevention efforts, we can live longer lives, healthier lives, and more productive lives. By using the knowledge that we have, people can change their lifestyles, feel better, and become healthier. We can save financially as well.

In 1987, we spent an average of \$2,000 for each American, or approximately 11 percent of our gross national product, on health care. Yet, only a small fraction of that amount was spent on prevention efforts. It has been reported by the Insurance Association

of America that businesses can save as much as \$6 for every \$1 spent on preventative care. We can no longer afford to emphasize only the treatment factor of the health care equation, while putting so few resources into less costly prevention activities.

The Health Objectives 2000 Act builds upon a program that is already in place, the Preventive Health and health Services Block Grants. States have been working on prevention efforts, and many have coordinated such efforts with 1990 Health Objectives that were developed by the Public Health Service in 1980. In my State of Utah, programs have been developed in the area of prevention for cardiovascular disease and hypertension control. These programs have been very effective. The death rate due to premature cardiovascular disease has decreased in Utah by 21.7 percent since 1981.

This bill would allow States to go beyond these efforts and, in partnership with local agencies, achieve the goals for improved public health that will be set by the Health Objectives for the Year 2000 project. This bill will ensure a concerted national effort for the States, localities, and the Federal Government to work together in addressing the most pressing public health issues that face this Nation.

I am pleased to cosponsor this bill along with my colleagues, and I applaud the Association of State and Territorial Health Officials who believe that this bill will enhance their ability to establish State and community-based prevention programs. Coordination and cooperation are key objectives if we are to upgrade health promotion and disease prevention efforts in our Nation.

Senator HARKIN. Thank you very much, Senator Pell and Senator Hatch.

Dr. McGinnis, again, welcome to the hearing, and your statement will be made a part of the record in its entirety. In the interest of time, if you could summarize it within a due amount of time, I would sure appreciate it. Thank you.

STATEMENT OF J. MICHAEL MCGINNIS, M.D., DEPUTY ASSISTANT SECRETARY FOR HEALTH, DISEASE PREVENTION AND HEALTH PROMOTION, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Dr. MCGINNIS. Thank you, Mr. Chairman, Senator Pell. I am, indeed, appreciative for the opportunity to appear before you today and commend you for your leadership in focusing attention on these vital issues for the Nation.

My comments will, I hope, be brief. They will mirror your comments. Indeed, you have eloquently made, both in your comments and in your graphic representation, our case for us in many respects.

This is a hearing with a hopeful theme, one that I think carries a message of opportunities at hand if the Nation can only apply its rather considerable resources in a more effective manner. It was in that same spirit that the Surgeon General, at the dawn of the last decade, called for a decade-long effort to reduce preventable disease and disability to achieve measurable goals for people at every stage of life. In this report, "Healthy People," the Surgeon General

called for achieving over the decade of the 1980's a 35-percent reduction in infant mortality, a 20-percent reduction in childhood mortality, a 20-percent reduction in adolescent and young adult mortality, a 25-percent reduction in adult mortality, and a 20-percent reduction in sick days for older people—that is, an improvement in the quality of life for older people.

This call for quantified goals to be attained for every life stage of the American people was accompanied by issuance of a broad range of objectives in 1980, identified as important priorities in this document, if we want to attain these specific quantified targets for the American people. There were 226 objectives in all, across 15 areas, ranging from tobacco and nutrition to environmental health, from family planning and maternal and child health to high blood pressure control and so forth.

Also issued then by a coalition of public health organizations was a set of model standards for community-based programs, an instrument to translate the objectives at the local level. And the American Public Health Association and the Association of State and Territorial Health Officials, as well as the county and local health officials, have played a role in moving that effort forward.

The progress since that time has been substantial. A mid-course review which was undertaken in 1985 indicated that we had achieved roughly half of our 226 targets. Around a quarter of them were not likely to be achieved—I should say half were either achieved at that point or were likely to be achieved by the target date of 1990. A quarter were not likely to be achieved, and another quarter we had inadequate information in support of the efforts to give a good sense of where we were.

The most recent available data at this point from 1987 indicate that with 3 data years left in the decade, we have come 80 percent of the way to our target of reducing infant mortality by 35 percent; we have already met our target of reducing childhood mortality by 20 percent, and exceeded it; we are about 70 percent of the way toward our target of reducing adolescent and young adult mortality by 20 percent; and we are nearly 85 percent of the way toward meeting our target of reducing adult mortality by 25 percent. That is with 3 data years still left in the decade. So the progress overall has been reasonably good.

In addition, a number of States are setting their own targets. In 1985, with the survey undertaken at that time, about a third of the States had set their own targets tailored to their local needs and conditions. As of last year, all but one had begun, and that one now has a program under way as well. So there is a tremendous amount of interest and activity as well as progress out there.

Because the progress we have had gives hints of the potential for this kind of an approach, 3 years ago we wrote to the Governors and the State health officials and other public health leaders around the country to get their views of the objective-setting process and suggestions on the future. We had interesting feedback from that solicitation that I would like to share a little bit with you in summary fashion.

We found testimony to the utility of the process on a number of dimensions. First, we heard that it was helpful in clarifying our opportunities and priorities. It helped to focus us to look at how much

of our burden of suffering ought to be preventable, given current knowledge, and it helps us to realize that though the headlines may focus on heart operations and liver transplants and other procedures that cost tens of thousands, often hundreds of thousands of dollars each, a modest investment to reduce, for example, smoking in the Nation from 35 percent of adults to the target level of 25 percent could save over the long run 100,000 lives every year among the American people. It helps us, in sum, gain perspective, and it also helps us to chronicle our successes. That is not unimportant when you are talking about prevention. Prevention, after all, is an area in which the often spectacular accomplishments occur, by definition, absent any spectacle, and we need a means of chronicling our accomplishments.

On the other hand, we also learned that the flip side of that is true as well. We need to be held accountable for our failures, and this kind of a process helps us to be held accountable. For example, even though the Nation as a whole is moving reasonably well toward achieving its overall goal of reducing infant mortality by 35 percent, we are going to fall far short of the goal of reducing infant mortality rates among our black population—of narrowing the gap, if you will. When that became apparent, when that failure became apparent in the middle of the decade, it was the subject of headlines and newspaper editorials around the country. That is exactly the way it ought to be. If we as a society are not achieving the goals that we set out to attain, we ought to be held accountable; we ought to be asking why we are not achieving those goals.

Third, we heard from States and other public health officials that these objectives were useful in providing a common language for us to communicate amongst each other and to communicate with our colleagues in other sectors—our colleagues in the education sector and the transportation sector. It is important that we increase our momentum by enlisting the support not only of all members of the public health community but those in other communities, and having a common language of this sort helps in many ways.

We heard, in addition, that having the national set of targets out there was useful as the national validation for initiatives at the State and local level. For example, we heard from the maternal and child health director in Mississippi that she was able to use the existence of national targets in the area as a means of working with her Governor, of convincing her Governor and her State legislature of the importance of the programs. So there is utility in having the national target.

Finally, we heard—and not unimportantly at all—that having the targets out there gave us a clear sense of where our gaps in data collection were: where we were not collecting adequately, where we needed to shore up our data system in order to give us a sense of the progress we were making or not making.

In sum, we have made progress, but compared to what is possible we have fallen short of the mark. Still, between 40 and 70 percent of premature mortality in this Nation ought to be preventable now, given what we now know. This is especially true for the populations most vulnerable, and we need to strengthen and refocus our efforts on those dimensions. As a result, in the extensive national

effort that you describe now under way to fashion objectives for the year 2000, three themes have emerged prominently in the course of that effort:

First, the need to give greater attention to those special populations, those populations most in jeopardy. And over 120 targets have been drafted at this point for populations including blacks, Hispanics, and Indian Americans, strengthening the focus on those groups;

Second, the need to broaden our focus beyond mortality to embrace quality of life issues. It is important that we look beyond just the notion of increasing the quantity of life;

And, third, the need to catalyze the interest and attention at the grassroots level across the country in order to achieve our overall targets.

Thank you, Mr. Chairman, for the opportunity today to give special emphasis to those themes. I would be pleased to answer any questions you may have.

Senator HARKIN. Dr. McGinnis, thank you very much for a very fine summation of your written testimony.

First of all, I would like to commend you and your staff for all of your efforts in developing health objectives for the Nation and, in particular, adopting what you have just talked about—your management by objectives approach—because it does do all the things that you said. It shows you where the gaps are. It makes us accountable when we fall short. And that is the way it ought to be. That is why I am so enthused about, again, setting out these objectives. Taking a look at what happened in the last 10 years, where do we fall short, and then getting these objectives implemented so that we don't fall short on these when the year 2000 comes around.

In the draft objectives, you State that you are placing increased emphasis on prevention of disability and acquiring better morbidity data. There is a real lack of morbidity data, and it makes it difficult to set goals for preventing disabilities. Preventing disabilities is a top priority of mine. We know how many children, for example, die from drownings, but how many are disabled from drownings? How many kids are disabled from not wearing a helmet when they are riding bicycles? Do we have that kind of data?

How will you be approaching this issue in the final objectives? In other words, the issue of disabilities, not only just preventing death but also disabilities.

Dr. McGINNIS. Well, I appreciate your asking me that question, Senator, because it is a very important issue. I noted the general themes that were emerging as the course of our work on the year 2000 objectives, and two of those themes included special populations focus and quality of life focus. And, indeed, the disability issue is picked up in both of them quite extensively.

Let me mention three ways in which disabilities will play a prominent role in the year 2000 objectives. First, primary prevention of disabilities courses throughout the objectives. We have 21 draft priority areas now; 15 of them are intimately focused on primary prevention of disabilities. Indeed, at the risk of going on for a little bit, I would like to just read some examples.

We have targets related to growth retardation, blood lead poisoning, fetal alcohol syndrome, low birth weight, substance use risk

through pregnancy outcomes, child abuse and neglect, unintentional injury hospitalization, spinal cord injuries, head injuries, workplace-related injuries and illness, mental retardation, preconceptional genetic counseling, and so forth and so on. That is about a third of the list of disability-related objectives that we have and are in the process of identifying. That does not include our focus on disabilities related to heart disease and cancer, which, of course, are also prominent sources of disability. In addition, one of the 21 priority areas has been renamed, and it is now called "Other Chronic and Disabling Conditions," to give additional emphasis on the area of disabilities.

As you mentioned, because of the poor information we have on various aspects of disability, and in particular on prevention of secondary disabilities among the disabled populations, we have made a special focus in the surveillance and evaluation category on increasing and improving our efforts to collect data among the disabled and around the disabled population. So it is a very important issue. I am glad you pointed it out, and we hope to do better in the coming decade.

Senator HARKIN. In the national health objectives act, what can we do to increase the public awareness of the need for a more aggressive and broadly based public health program in America? Before we came out here, I was telling my staff earlier that when I was a little kid living in a rural community of 150 people in Iowa, right after World War II—let's see, I would have been about kindergarten, 1st grade—evidently, the Nation went on a big public health binge then, and we all got inoculated. I remember the public nurse would come around and make sure we had our smallpox and our measles, all these different shots. We had fruit juice to drink every morning. We would line up and get our cup of fruit juice. That is something that had never been done before in the small rural areas. Well, that was considered public health. My whole idea of public health started right there when the public health nurse came around.

It seems that we have to broaden that concept today and to reinvigorate the whole aura of public health in this country; that prevention of illness and disease and the promotion of good health should not be just a personal responsibility, but it should also be a public responsibility. If you get sick and you need help, people don't say, well, take care of yourself. You go see a doctor; you go to a hospital. You have all kinds of people that you go to to take care of you. Yet, for prevention of illness and for promotion of health, we seem to have, at least over the last few years, taken the attitude, well, that is not part of the public domain, leave that up to the individual. Many times the individual doesn't have the information or the wherewithal, especially in certain targeted groups—low-income groups, inner city, rural areas. They don't have the wherewithal, and they don't have the knowledge for prevention and health promotion.

I just sort of state that as an observation and hope that in this Health Objectives Act that we have a part of it that is designed to have some measurable objective of how we get this information out. How do you reach out to people? How do we make people aware of public health services? I think by making them aware

that they will demand it. And by demanding it, they will put the pressure on people in public positions to ensure that we fund promotion and prevention.

Is that a part of this? Is that a part of the health objectives?

Dr. McGINNIS. Well, I think it is a vital part of it, Senator. Indeed, to oversimplify somewhat, one of the very purposes of the sort of thing that you are focusing on with Health Objectives 2000 is to improve perspective—perspective of the public, of the Nation—on what is achievable.

Another important part of that, and hopefully derived directly from it, is the stimulation of activity at the State, local, and community level, to act on that perspective. What better way to provide perspective and to catalyze activity than to lay your objectives out quite explicitly, to give a sense of people about where the pay-offs lie.

If you look down the deficiencies that currently exist in the Nation, you can see that while we are doing reasonably well with tobacco overall, there are still 390,000 deaths a year as a result of tobacco. That is over a denominator of two million. That is about one in every five deaths. That is quite a few. If you look at the impact of diet-related issues, the burden is around another 300,000. Alcohol, 18 million alcoholics in this country with 100,000 death. Drugs, 6.5 million. Sexually transmitted diseases, 12 million.

There is a common thread coursing throughout each of those problems. That common thread is that personal behavior is an important element. But, as you point out, personal behavior isn't changed by waving a magic wand. We can't just say to individuals, Go thee forth and change the way you operate. What is clear is that we need greater efforts to stimulate a supportive network at the community level where people are.

The national Government, in fact, does quite well at developing magic bullets through its marvelous research enterprise. But in this case, where we are talking about behavior, magic bullets aren't going to work. We need to have the stimulus for supportive activity, motivational work in the neighborhoods and in the communities. And I think by focusing through the establishment of specific and measurable objectives at each level, you are providing the kind of motivation to get those things under way.

Senator HARKIN. You said there were 390,000 deaths per year attributable to smoking. I was visiting a cancer center a few days ago in another part of the country, and the director of this cancer center had formally been at NIH, at the National Cancer Institute. He has an interesting observation. I was just figuring it out here. His figures basically track yours. He said that every day in the United States there is the equivalent of two-and-a-half 747's crashing and killing all the people on board due to smoking.

Dr. McGINNIS. That is right.

Senator HARKIN. Two-and-a-half 747's every day. He also pointed out that for cancer research we spend about \$1.6 billion a year for all cancer research, yet the tobacco companies spent \$2.8 billion just in advertising. It kind of puts things in perspective.

Dr. McGinnis, again, I thank you very much for your testimony, and we look forward to the published data in September. Of course, we have seen the initial draft. We hope to get the bill through

some time this summer so that it tracks with the publication of the report in September.

Dr. McGINNIS. Thank you very much.

Senator HARKIN. Senator Cochran.

Senator COCHRAN. Mr. Chairman, let me just offer my congratulations to Dr. McGinnis and, through him, to Secretary Sullivan for the fine, aggressive job that they are doing to try to attract attention to the importance of preventive health activities and measures that can be taken to try to keep our society healthy and not have to rely upon all the various health care services required when we get sick. Keeping our society well is a big challenge. However, it is something that is going to pay big dividends for us, economically and in terms of emotional well-being as well.

If you took a poll in this country today and asked people what concerns them most, I would bet you that the number one item would be getting sick or getting a disease or having to go to the hospital—a health-related matter that concerns the American people—because of the devastation that that can cause financially and all the other risks that are associated with disease and being sick. So keeping everybody healthy I think is something we really need to work harder on, and acquainting them with measures that they can take for their own good is really a big part of that challenge.

I think you are on the right track. Congratulations. We are going to support you in your efforts.

Dr. McGINNIS. Thank you very much, Senator Cochran. We, of course, in the Public Health Service certainly view the Government's fundamental obligation as enhancing the health and well-being of the American people, and I will certainly pass your comments along to Secretary Sullivan.

Senator COCHRAN. Thank you.

Thank you, Mr. Chairman.

Senator HARKIN. Thank you, Senator Cochran. Thank you, Dr. McGinnis.

Dr. McGINNIS. Thank you.

[The prepared statement of Dr. McGinnis follows:]

PREPARED STATEMENT OF J. MICHAEL MCGINNIS

Mr. Chairman, I am Dr. J. Michael McGinnis, Deputy Assistant Secretary for Health for Disease Prevention and Health Promotion with the Public Health Service of the U.S. Department of Health and Human Services. I appreciate the opportunity to participate in this hearing today on the Health Objectives 2000 Act. This is a hearing with a hopeful theme, one that carries a message of opportunities at hand. Although some of America's most intractable health problems -- adolescent pregnancy, black infant mortality, drug abuse, and even heart disease and cancer -- are exacerbated by conditions beyond the reach of the public health apparatus like lack of education and income, the public health system is by no means powerless. How well we deploy available resources, the extent to which policies favoring preventive medicine transform medical clinics from illness care to health care settings, and our efficiency in implementing scientific discoveries can make a big difference in the health profile of Americans. Meeting these challenges, in turn, depends on effective planning, appropriate reimbursement, and the timely application of the fruits of biomedical research.

The 1990 Health Objectives for the Nation

When opportunities and needs are great and resources are limited, as they are for the national disease prevention and health promotion agenda, we must pick our battles carefully, where effort is most likely to yield results. As you know, a mechanism for doing so is already in place. In 1980, the Public Health Service presented a 10-year strategy for setting and pursuing goals and for measuring progress, initiated in 1979 with publication of Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention and established in 1980 with the publication of Promoting Health/Preventing Disease: Objectives

for the Nation. Adopting a "management-by-objectives" planning process familiar in the world of business, the Public Health Service set out 226 objectives addressing improvements in health status, risk reduction, public and professionals awareness, health services and protective measures, and surveillance and evaluation expressed in terms of measurable targets to be accomplished by 1990. These objectives were organized in 15 priority areas under the headings of preventive services, health protection, and health promotion.

The 1990 campaign has been more than a codification of targets for health improvement. It has set in motion efforts to achieve them. Each of the 15 priority areas was assigned to an appropriate lead agency within the Public Health Service. These agencies in turn have developed implementation plans that called for reaching out beyond the Department of Health and Human Services to include participation elsewhere in the Federal Government, at the State and local level, and in the private sector. The Federal Government is providing financial support, technical resources, and information, but the most critical activity is at the State and community level, where improvements in individual and collective health must occur. For example, Federal programs are in place to encourage good infant and maternal nutrition, fluoridation of water, and control of sexually transmitted diseases. However, these programs will succeed only if they have State and local leadership.

The whole system of disease prevention and health promotion depends on knowing where we are so that we can judge how far we have to go and how best to get there. Data are gathered by a variety of means and analyzed by the responsible agencies and organizations. Each

month the Assistant Secretary for Health chairs a meeting with the lead agencies to evaluate the progress they have made toward achieving their assigned objectives and to discuss barriers they have encountered or foresee. The Public Health Service shares these progress reports with health professionals and the public through a range of official, professional, and lay channels.

The States are also setting and pursuing goals for improved health. As of two years ago, nearly 85 percent of States and Territories had established State objectives for at least some of the priority areas of the national 1990 objectives. Eight of the others had begun the process. People at the State and local level have testified to the utility of having specific, measurable goals for their domains.

In 1985, an interim assessment of progress toward the 1990 objectives resulted in the publication in 1986 of The 1990 Health Objectives for the Nation: A Midcourse Review. The following year, a steering committee was formed within the Public Health Service to oversee the process of revising the objectives for the year 2000.

Developing Objectives for the Year 2000

The year 2000 objectives build upon the 1990 objectives effort. The approach taken in developing year 2000 objectives parallels the 1990 objectives in the comprehensiveness of the issues it addresses. However, it is much broader in terms of the scope of participation. As a

first step, the Assistant Secretary for Health invited more than 200 national membership organizations and all the State and Territorial health departments to join the Public Health Service in a national consortium in support of the year 2000 objectives development effort. In addition, the Public Health Service established a partnership with the Institute of Medicine, National Academy of Sciences, and they jointly convened a series of seven regional hearings across the country. Using the input and expert views gleaned from the public hearings, the Public Health Service Steering Committee defined 21 priority areas to serve as the initial framework for drafting the year 2000 objectives.

The year 2000 priorities expand upon and revise those of the 1990 objectives, with the addition of areas focused on topics such as HIV infection, food and drug safety, and mental health. The new objectives are also characterized by an increased emphasis on prevention of disability and morbidity, greater attention to improvements in the health status of definable population groups at highest risk of premature death, disease, and disability, and inclusion of more screening interventions to detect asymptomatic diseases and conditions early enough to prevent early death or chronic illness.

Since September 1988, work groups, organized by Public Health Service agencies assigned to be "lead agencies" for each of the priorities, have been crafting new objectives for the year 2000. In developing the draft year 2000 objectives, work groups were guided by eight principles:

Credibility: Objectives should be realistic and address the issues of greatest priority.

Public comprehension: Objectives should be understandable and relevant to a broad audience, including those who plan, manage, deliver, use, and pay for health services.

Balance: Objectives should be balanced between stating what should be done and how it should be done, recommending methods for achieving changes and setting standards for evaluating progress.

Measurability: Objectives should be quantified.

Continuity: Year 2000 objectives should be linked to the 1990 objectives where possible, but reflect the lessons learned in achieving them.

Compatibility: Objectives should be compatible where possible with goals already adopted by Federal agencies and health organizations.

Freedom from data constraints: The availability and form of data should not be the principal determinant of the nature of the objectives. Alternate and proxy data should be used where necessary.

Responsibility: The objectives should reflect the concerns and engage the participation of professionals, advocates, and consumers, as well as State and local health departments.

Quantifiable targets for improving health status, reducing risk factors for disease and disability, and improving services set out a prevention agenda for the 1990s. Priorities have been established for the areas of health promotion, health protection, preventive services, and overall system improvement:

The area of health promotion presently includes eight priorities: physical activity and fitness; nutrition; tobacco; alcohol and other drugs; family planning; mental health; violent and abusive behavior; and educational and community-based programs.

The area of health protection includes five priorities: unintentional injuries; occupational safety and health; environmental health; food and drug safety; and oral health.

The preventive services area includes eight priorities: maternal and infant health; heart disease and stroke; cancer; other chronic and disabling conditions; HIV infection; sexually transmitted diseases; immunization and infectious diseases; and clinical preventive services.

Another priority area is surveillance and data systems. Although each priority area includes discussion of specific data, health personnel, and research needs of each area, this area assesses data issues broadly and includes objectives to improve the overall national health data system.

In addition, four age-related priorities -- Healthy Babies, Healthy Children, Healthy Adolescents and Youth, and Healthy Older People -- will be constructed from objectives in the other priority areas. Those interested in developmental stages will be given a complete set of objectives organized by age group rather than disease, risk factor, or intervention.

Participation in the national health objectives process is evidence of a growing social commitment to, and accountability for, health. Before their release this fall, the objectives will have undergone the scrutiny of thousands of public health experts across the country. Thirteen thousand copies of the draft objectives were distributed to national organizations,

State health departments, and concerned citizens. Approximately 600 groups and individuals supplied us with comments and suggestions for improving the draft.

Public Health Service lead agencies have reviewed the public comments and these suggestions are being incorporated to the extent possible. For example, many public comment submissions expressed concern that the draft health objectives did not address the broad area of family planning, focusing instead on the negative consequences of sexual behavior such as adolescent pregnancy and sexually transmitted diseases. In response, we have renamed the chapter Family Planning and broadened its scope to include the larger issue of preventing unintended pregnancy. We are fully committed to developing a set of disease prevention and health promotion objectives that are truly national in scope and responsive to the expressed needs of health professionals, State government, and community and business leaders.

State Roles in the Health Objectives

We are very supportive of the goals and purposes of the Health Objectives 2000 Act. Since publication of the 1990 health objectives, the Public Health Service has worked with the States, encouraging use of the national objectives as a bench mark and plan of action and also as a model for the State's own health objectives. One measure of success in achieving a nationwide commitment to disease prevention and health promotion is the extent to which States have adopted this focus and developed specific strategies for accomplishing the national or state-specific goals. The first summary of State progress toward achieving these

goals came in March 1986, in a report prepared by the Intergovernmental Health Policy Project for the Office of Disease Prevention and Health Promotion. The report examined how the national challenge to emphasize disease prevention and health promotion had been received by the 50 States. Specifically, the report examined how the States had interpreted that challenge and what strategies they had used to implement their own objectives. The report found that as of October 1985, when data collection was completed, there were clear and visible signs in most States that the message of Healthy People and the 1990 national objectives was being heeded.

In December 1987, the Public Health Foundation surveyed health departments in all 50 States, the District of Columbia, and four U.S. Territories. The survey attempted to determine if States had established, or planned to establish, disease prevention/health promotion objectives. The survey found that the establishment of disease prevention and health promotion objectives has become an accepted part of States' health agendas across the country. Fifty-four States and Territories responding have established their own objectives for at least some of the 15 priority areas of the national objectives or have begun the process of establishing objectives. Forty-six have established objectives, and eight have begun the process. At the time of the survey, only Arkansas indicated that it had done neither. We understand that at this time Arkansas has scheduled work group meetings in early May to establish health objectives for the State. This indicates a substantial increase in activity when compared with the 18 States that had completed their own set of objectives for 1990 or beyond as of October 1985.

We have also included the States in each step of the development of the year 2000 national objectives. All fifty States, the District of Columbia, Guam, American Samoa, and Puerto Rico are members of the Healthy People 2000 Consortium; all State health departments received copies of the draft year 2000 objectives for review and comment, and approximately 25 States submitted suggested revisions to the document. In addition, we anticipate that most States and territories will send representatives to our Healthy People 2000 kick-off conference in early September where break-out and working sessions will be devoted to showcasing State activities that support the health objectives.

The Public Health Service's commitment to accountability is evidenced by publication of the Midcourse Review of the 1990 Objectives and monthly meetings with the Assistant Secretary for Health to review progress toward the objectives. In 1986, we published our findings that approximately half of the 1990 objectives had been met or were on track and projected to be met by 1990. Approximately 25 percent were unlikely to be met and approximately 25 had insufficient data to evaluate progress. The Midcourse Review enabled the Public Health Service to take stock of progress and redirect efforts as necessary. In keeping with our commitment to accountability, Dr. Mason will ask that future Public Health Service agency budgets submitted to him indicate their link to achievement of the national health objectives.

Resources for Achieving the Year 2000 Objectives

Clearly, we must make better use of funds that have already been allocated to public health.

We can do a better job of achieving the national health objectives. We can do better by being more focused in our pursuit, by improving coordination among Federal, State, and local health departments, and perhaps most importantly by broadening our base of partners. We cannot afford to leave out of our national health promotion and disease prevention strategy all of those sectors and actors whose actions affect the health of Americans. We must continue to broaden our base of support to include employers, the producers of health related products and services, food retailers, our Nation's schools, and local government -- from the office of the Mayor to the department of public works and recreation.

We are committed to moving disease prevention and health promotion beyond the medical system. For example, our consortium of national membership organizations, organized in late 1987 by the Public Health Service and the Institute of Medicine (IOM) of the National Academy of Sciences, reaches a broad base of groups with an interest in health. There are currently over 300 organizations in the Consortium, representing national professional and voluntary organizations and State and Territorial health departments. Active partners in the development process, Consortium members have participated by suggesting speakers for 25 public hearings, submitting testimony on the objectives, and suggesting reviewers for early drafts of the new objectives.

Currently, all State health departments are members of the Consortium, but it also includes such groups as the Salvation Army, the National Recreation and Park Association, the National Conference of State Legislators, the Business Roundtable, and Grocery

Manufacturers of America, Inc. All Consortium members received the draft health objectives and were invited to suggest revisions. A two-day hearing, convened in cooperation with the Institute of Medicine to take suggestions for revising the draft, attracted approximately half of the Consortium members. We will continue working with Consortium members to implement the year 2000 objectives.

We are also committed to improved coordination and integration with State and local activities. Shortly after Healthy People 2000 is published in September 1990, a new addition of Model Standards, entitled Healthy Communities 2000: Model Standards -- Guidelines for Community Attainment of the Year 2000 Objectives for the Nation will be available as a companion document to help put the objectives into practice at the State and local level. This newest edition of Model Standards will be closely integrated with the national objectives, and unlike previous versions, will include the exact language of the national health objectives.

The Model Standards are being revised as a collaborative effort of the American Public Health Association, the Association of State and Territorial Health Officials, and three other national health organizations, in cooperation with the Centers for Disease Control. To ensure effective integration with the objectives, the Model Standards Steering Committee has worked closely with the work groups formed to draft the year 2000 objectives.

Many of the year 2000 health promotion and disease prevention objectives aim specifically at improving the health of populations that are at higher risk for morbidity, disability, or

premature death. To help meet these new targets, the Office of Disease Prevention and Health Promotion has entered into cooperative agreements with national membership organizations that represent special populations, to help stimulate development of targeted health promotion and disease prevention programs and policies. Cooperative agreements have been made for:

American Indians/Alaska Natives, with the American Indian Health Care Association

Asian/Pacific Islanders, with the Asian American Health Forum

Blacks, with the National Medical Association

Hispanics, with the National Coalition of Hispanic Health and Human Services Organizations

Adolescents, with the American Medical Association

Older People, with the American Association of Retired Persons

People with Disabilities, with the American Association of University Affiliated Programs for Persons with Developmental Disabilities

As part of our commitment to reaching beyond traditional public health avenues, we have entered into several cooperative agreements with organizations that will take the year 2000 national health objectives to new settings and audiences with targeted promotional messages. These cooperative agreements include:

Children in schools, with the American Association of School Administrators

Worksites, with the National Worksite Health Promotion Resource Center

Clinical settings, with the American Hospital Association

A related cooperative agreement, with the Denver-based National Civic League, promotes the concept of "Healthy Communities" -- communities working to improve their health and quality of life by incorporating the views and resources of all community members in solutions to locally defined problems.

Conclusion

All of these efforts, from the initial public hearings, to creation of the Healthy People 2000 Consortium, to expanding coordination and cooperation with new partners for health promotion, are intended to prepare the Public Health Service for smooth and effective implementation of the national health promotion and disease prevention objectives. The most effective way of improving the public's health will be to continue working with the States, strengthening and expanding collaboration and coordination, and working with them to broaden our base of support outside the traditional public health community, reaching out to the multiple sectors that affect our health, including local government, employers, the schools, and insurers. It is a vital effort.

Thank you, Mr. Chairman. I would be pleased to answer questions.

Senator HARKIN. Next we have a panel of consumers: Jack and Ramona Brooks, Congregational United Church of Christ, Rock Rapids, IA; Herrestine Chambers, Program for Improved Nutrition and Health, Greenwood, MS. We've got Iowa and Mississippi covered. And Emily Holing and her daughter, Erin, from Bellevue, WA.

Welcome to the subcommittee. I will just call on each of you in the order which I have read it here. I guess it is in alphabetical orders: Brooks, Chambers and then Holing. We welcome you all here. Mr. and Mrs. Brooks, Reverend and Mrs. Brooks, I understand you now live in South Dakota, though. Well, that is all right.

Welcome. Your statements will all be made a part of the record in their entirety. If you could, just take about 5 minutes to summarize and tell us what you really want us to know, to remember as we walk out of here.

Reverend Brooks, and then we will go right on down the line.

STATEMENTS OF REV. JOHN H. AND RAMONA J. BROOKS, CONGREGATIONAL UNITED CHURCH OF CHRIST, ROCK RAPIDS, IA; HERRESTINE CHAMBERS, BELZONI, MS, PROGRAM FOR IMPROVED NUTRITION AND HEALTH, GREENWOOD, MS; AND EMILY HOLING AND ERIN HOLING, BELLEVUE, WA

Rev. BROOKS. Thank you, Senator. I guess it is important that you know how I first became aware of this Federally funded Adult Health Screening Clinic. I was chairman of the Lyon County Health Council, and the purpose of that was to promote health through coordinating various health agencies of the county, whether it was Red Cross or homemakers or a public health nurse. It was at such a meeting that the public health nurse shared with us the desire to write for this grant, but one of the requirements would be that there would have to be a facility that would be furnished gratis. And so I volunteered our church. Then when the clinic was approved and we were going to be hosting the first one, I said to my wife I want us to go through that simply to see how professionally they carried it on. We both thought we were in good health.

I think it is important that you know something of the nature of that program. The nurses preferred to call it a health assessment rather than a physical exam. They are not in competition with doctors but are in a team relationship, seeing their relationship twofold: one, referral, and the other health education. They take from an hour-and-a-half to two hours with the patient. It is a little different than when you are taking a physical from a very, very busy doctor. It is not a put-down to the doctors, but the nurses simply take the time.

The first part of the screening is kind of a conference level where they assess our family past health history, and then my own health habits such as diet, sleep, schedule, how busy am I, drinking, smoking, all that, and then how do I feel about my own health, are there any problems that I have. They assess this, and then there is a complete physical, all except rectal and genital, and then there is lab work: blood testing for cholesterol, hemoglobin, sugar, and urinalysis.

Then the closing session is what they found about us, and I expected that I would be in good health. Instead, she said, "From the things you have said to me and from the lab work, you need to be referred to a urologist. I think there are some abnormalities with your prostate gland."

I did postpone that until we had actually moved. I retired as a pastor and moved to South Dakota, and I knew there would be a physical involvement in the moving. So I decided, for better or for worse, to not go to the urologist until I actually lived in Sioux Falls, which I did. From his examination, he discovered that I had cancer. The medical term is Gleason 2-2, Stage B 1.

Early detection was the key here. I had surgery. It was completely contained within the organ, and I no longer have—I didn't have to have any radiation or any chemo at all. I will be having follow-ups in terms of just being cautious.

So I would like to say, in conclusion, I know that that clinic spared my health and possibly my life. I feel very strongly about that. Second, it is good to be a part of a program where we see people such as the economically deprived who might not have that opportunity except for this screening clinic. Many said it is less threatening. It is less threatening to go to this clinic than to go to a doctor's office. There was more of a willingness. Others felt that as you are getting older, driving is a problem. Sioux Falls is small by comparison to DC, but, believe me, for some of these people, the drive in Sioux Falls is catastrophic. So to be able to go to a little community with people they know was very reassuring.

A very important part of the clinic's work was educational, in teaching them better health habits, better diet, this type of thing. She said that over 50 percent of the clients were referred to specialist, such as myself.

I thank you, Senator, for allowing me to share. If you want to ask any questions, I would be glad to do that.

Senator HARKIN. Thank you very much, Reverend.

Mrs. Brooks.

Mrs. BROOKS. Thank you, Senator Harkin.

The Adult Health Screening Clinic played an important role in my good health today. I went through this clinic, as my husband did. The nurse spent about an hour-and-a-half to two hours with me, taking down the history, as he already reported, asking me questions about what kind of work I am able to do, if I am able to do my own work and so on, diet, exercise, and so on. And I told her about a problem I had had for the last month. Based on that, plus the high sugar count that I had, which she told me later could indicate some kind of an infection, she informed me that I should go see my physician.

I did go for a doctor's appointment and had a Pap test. A few days later, I had to return for some blood work, and the physician told me that I had some abnormal cells and I must see a specialist. This was on a Friday, and he made the arrangements, and I was to see the specialist on Monday. So I suspected that something quite drastic had happened because usually you don't get an appointment that soon.

I went in, and the first thing he did was to talk to me, and he said, "Mrs. Brooks, you have cancer"—a very frightening state-

ment, to say the least. He said, "From the report that your physician sent in, this is what I conclude." And I said, "Well, he didn't tell me I had cancer. He just said I had some abnormal cells."

So the gynecologist did an examination, took a biopsy, and said I needed surgery. So I had a complete hysterectomy done. Fortunately, the malignancy was a tumor about the size of a quarter. It was in my uterus. It had not broken through the wall, and it was all contained. And the report came back from the lab that I did not have to undergo any chemotherapy or radiation. So I was very, very thankful.

The key to my success story is early detection, and I attribute this to the Adult Health Screening Clinic. As many of you know, the Midwest has many small towns that do not have medical facilities, and people have to drive great distances and even more so to go to a specialist. And these health screening clinics play a very important part in the fact that people are able to go there, it is cheaper—as my husband has already pointed out. They were given free, but they did take donations. And I think people were happy to make some donations, but this was still cheaper than going to a specialist. About 50 percent of the people were referred to specialists. So I am one who would sing the praises of adult screening health clinics because it did save my life.

Thank you.

[The prepared statements of Rev. and Mrs. Brooks follow:]

THE TESTIMONY OF RAMONA J. ANDERSON
REGARDING HER VISIT TO THE
ADULT HEALTH SCREENING CLINIC
January 31, 1989
Rock Rapids, Iowa

The Adult Health Screening Clinic played an important role in my good health today.

The nurse at the Clinic did a complete history of me asking questions about my living habits, work that I do, diet, exercise, sleep patterns, past health history and then did a review of my body systems starting with my head down to my toes. She was very thorough spending about 1 and 1/2 to two hours with me. I told her I had a very slight vaginal discharge occasionally for the past month and wondered if I should be concerned, since I had not menstruated for the past eight years. This information along with the fact that my blood sugar was high prompted the nurse to say I better see my doctor soon.

Because of the assesment and referral of the nurse at the Clinic, I went to see my Doctor who did a physical and Pap's smear. A few days later I had to return for some blood work. My Doctor informed me that the results from the Pap's test were back and I had some abnormal cells. He made an appointment for me to see a specialist in Sioux Falls. Since this was a Friday and my appointment with the gynecologist was the following Monday, I surmised it was quite serious.

When I went to see the Gynecologist he informed me that my doctor's report said I had cancer, a very frightening word, to say the least. The Gynecologist did an examination and took a biopsy. It was determined I would have to have surgery. Acomplete abdominal hysterectomy was scheduled for the following Tuesday. They found I had a malignant tumor about the size of a quarter but it had not yet broken through the uterus wall. Lab reports came back saying all the cancer was contained and I did not have to have any radiation or chemotherapy treatments.

I go back periodically for check-ups and my Gynecologist says everything checks out fine.

Early detection was the key to my success story and I believe my rapid recovery from surgery was due to the fact I was not rundown from a long illness.

THE TESTIMONY OF JOHN H. BROOKS
REGARDING HIS VISIT TO THE
ADULT HEALTH SCREENING CLINIC
January 31, 1989
Rock Rapids, Iowa

Because the church I pastored in Rock Rapids, Iowa, was providing its facility gratis for the federally funded health screening clinic for senior citizens, I decided to go through the clinic to see how professionally it would be conducted. There I received a nurses assesment of my physical health. This involved an actual examination of the entire body (except genitals and rectum.) The result of the examination and interview raised questions by the nurse that I may have an abnormal prostate gland. She urged me to see a urologist for further medical examination.

Since I was anticipating retirement and moving to Sioux Falls, South Dakota, I decided to wait for the examination until after I moved to Sioux Falls where there were adequate medical centers. In the late fall I went to a general practioner, who, upon examining my prostate referred me to a urologist, Dr. John H. Hoskins. Further examinations and blood lab work by the urologist and his staff revealed that I did have cancer of the prostate. Surgery was scheduled for December 12th. Fortunately the cancer (Gleason 2-2, Stage B 1---Medical description) was still totally contained within the removed prostate gland; so no further treatment or radiation was necessary, and I am recovering very satisfactorily. I will need to go back for periodic check-ups to monitor my health to guard against further cancer growth.

I feel very strongly that if I had not gone to this health screening clinic, my health and possibly my life would have been in great jeopardy. There was something so much less threatening about going to this type of a screening clinic than going to a doctor's office for a physical examination. Since I had felt fine, there seemed no urgency for a physical examination. Obviously I should not have procrastinated as long as I did; but I wonder if I would have gone for a physical at all, if it were not for this easily accessible, non-threatening opportunity for this type of physical screening. In a way I feel I owe my life to this federally funded Health Screening Clinic that was held in my church at Rock Rapids, Iowa.

THE PROGRAM OF THE
ADULT HEALTH SCREENING CLINIC
Rock Rapids, Iowa
By John & Ramona Brooks

The following procedures were conducted in the screening program, as we experienced it and as it was reported by one of the staff professionals, Chris Vander Zee, RN.

The entire program involves an approximately two hour period with each patient, and consists of four phases.

The first phase is a lengthy interview which covers:

1. The social history of the individual (living habits)
2. Health habits (diet, exercise, sleep, etc.)
3. Past health history (both of the individual and family)
4. Review of the body systems (asking the patient about his/her health and bodily functions)

The second phase of the screening is the actual examination of the entire body (except for genitals and rectum).

The third phase is lab work: testing for blood sugar, hemoglobin, cholesterol and urine testing.

The fourth and final phase of the screening is a closing interview with the individual being examined, disclosing the results of the screening and possible referrals. Nurse Vander Zee reported that there were 50% of referrals actually made. Because it is a free clinic (though donations are accepted) many financially deprived people took advantage of this program.

The entire screening was done on a highly professional level, and was sensitive to the individual's privacy and confidentialities. The Clinics are conducted monthly throughout Lyon County, rotating to the three locations on a quarterly basis.

We cannot urge strongly enough that this program be continued, and if possible, expanding it to serve a wider age range of people. Many of our rural Mid-west towns are without Medical facilities and it is necessary for people to travel great distances to see a doctor. These Health Screening Clinics help people by teaching proper diet, exercise, and re-orient them into health fields by referring them to seek help if necessary.

From both of our experiences with this program, we feel that this screening clinic may well have saved our lives from cancer by alerting us in time to seek out additional medical specialists before the cancer had gone too far in our bodies.

Senator HARKIN. Thank you, Mrs. Brooks, Reverend Brooks.-I think we will go on down the panel and come back, but I want you to think about this. I am going to ask you about more information on how this came to be set up in your church and who approached who first and how this all came about.

Rev. BROOKS. Shall I answer that now?

Senator HARKIN. No. Let me just go on down the panel, but I want to come back to you and get more information.

Senator HARKIN. Next is Herrestine Chambers and also Robert Lingafelter from Greenwood, MS. Welcome.

Ms. CHAMBERS. Thank you, Senator Harkin. Good morning.

I want to thank all of you, especially Senator Thad Cochran, for inviting me here today to share with you our experiences as a community trying to improve the health of our neighborhoods.

Before I start, I need to bring you the greetings of Dr. Alton Cobb, our Mississippi State health officer. He is very concerned and interested in the Health Objectives 2000 Act.

My name is Herrestine Chambers, and I am a resident of Belzoni, Humphreys County, in the heart of the Delta region of Mississippi. I grew up on a farm just a few miles from Belzoni. Being the oldest child, I helped put all of my 6 brothers and sisters through college. I am now a widow who has raised 6 children on my own and have 6 grandchildren. I am a trained day care food service worker.

Humphreys County, my home, is one of the poorest areas in the State of Mississippi. With a population of 13,000, over 4,000 of these people receive food stamps every month. Without stamps, they would not make it. Sixty-seven percent of the babies are born to mothers at risk. Our infant mortality rate is 33 percent 1,000. Eleven percent of babies are low birth weight, 29 percent of births are to teenage mothers. In 1987, our accident death rate was even higher than the cancer death rate. The average schooling attained in Humphreys County is 9 years. Eighty-five percent of public school students are performing below the national average. As you know, industries do not move into an area where the work force cannot read.

Belzoni has seen a lot of progress in the last few years with our growing catfish industry, but we still have a lot of problems, a lot of unemployment, a lot of poverty, a lot of health problems. But we also have a lot of concern for our community, and that is what I am here to tell you about today.

Since 1988, I have been serving my community as a volunteer community health advisor with the PINAH program, Partners for Improved Nutrition and Health. Ever since I can remember, I have always helped my neighbors when I could. Our mother raised us this way. And people come to me for advice. But in 1988, I was invited to participate in health advisor training. We had the Health Department, we had private doctors, a home extension service, and they came and gave us the basic information about nutrition, health, safety, and community service. The PINAH staff showed us ways to use this information in our neighborhoods. Since graduation, after 10 weeks, we organized a clean-up campaign, we had a health fair, we had an economic development forum, and now we are in an emergency food pantry. Individually, I find that I help

about four to five families every week with different kinds of problems. I help sick children, I help my relative who is homebound, I show them how to apply for food stamps, I help people that are denied Medicaid benefits.

The PINAH program has lots of partners. The State Department of Health is the leading agency, the Cooperative Extension Service, the Freedom From Hunger Foundation, the Humphreys County Inter-Agency Council, and a statewide committee of advisors, and the 42 of us who are community health advisors in Humphreys County. Once each year we all meet together to review PINAH's long-range plans, and then the Health Advisors meet locally every month to plan our own neighborhood activities.

The program was started with a DHHS community food and nutrition program grant to the State Health Department in 1988, but since then, most of the funding has been private, through the Freedom From Hunger Foundation. There are 3 local churches in Belzoni who give money for the emergency food pantry, and a fair bit of money just comes out of our own pockets. Our Congressman, Mike Espy, arranged for a donation of staple foods last Christmas, and due to the cold weather, there was a lot of people that weren't able to get out and buy groceries because of the cold weather. So this food was helpful. And the restaurant chefs in Jackson organized a recent benefit called "A Taste of the Nation," which helped us fund the food pantry.

Let me tell you a little more about the ways that the health advisors helps in this community. People need advice: where to go, who to see, how to solve their problems. More than half of the people that we are helping are either over 60 or are teenagers. They get their help not only for illness, family problems, and where to go for help, but they also get a lot of emotional support, knowing that there are people in their neighborhood who really care about their well-being.

Then sometimes people need assistance. There was one senior citizen who had a stroke, and he was ready to come home from the hospital. But there was no one to take care of him, and the home health agency did all they could, and the welfare did all they could. But unless somebody else stepped in, that old man was going to end up alone and forgotten in a nursing home. His house was full of roaches. He didn't have any heat, the wind came in around the windows. Someone was cheating him out of his welfare money each month. So he really needed our help. Welfare and Home Health called us. Two health advisors went over and cleaned out his house, helped him home from the hospital, brought him hot meals three times a day, and got him a new bank account where he wouldn't be cheated. We visited him every day and finally helped him move into a new apartment that had just recently opened up for the elderly and handicapped. He is still as independent as he can be and very happy and proud about his new place. But without health advisors, he would still be where he was.

And then some problems need community action, like the food pantry we are working very hard on right now. Believe me, I lived in the area most of my life, but even I did not know how hard up some families are, that there are kids in our school whose only meals are the school breakfast and lunch. The advisors in Louise

have mobilized the entire community to support a senior citizen program that will include an activity center, a library, and a hot meal program. The health advisors in Isola are working on a community recreation program, summer youth activities, and a public park.

During the health fairs we did with the Health Department, we found a lot of high blood pressure. We found that about half of these people did not know they had high blood pressure. And of the people that had been diagnosed before as having high blood pressure, only about half of them were following their medications and diets. So we are doing lots of follow-up, getting people to go to the doctor, stay on their medication and diets, and helping them to solve the economic problems that cause them to run out of medicine or not eat the way they should. One way that we found to help the elderly to take their medication was put their medication in apricots or peaches or something that they wouldn't taste the medicine. That was one way that we helped them out.

The Health Department is responding with a special hypertension clinic twice a month. Many of our senior citizens live way out in the remote rural areas where the agencies cannot reach them, and it is hard for them to get into the towns and the services they need. As health advisors, we get out in the rural. We bring support to these people who are just not linked into the system in any way.

Health advisors are helping an average of 168 families per week, about twice as many as we were just naturally helping before our training. Together with the Health Department, we expect to see the impact of our work in fewer infant deaths and low birth weights, more people using the available health services, and more people knowing how to live and eat to take care of their health.

While it is too early for the statistics to show a lot of impact, health advisors are helping an average of 168 families per week, about twice as many as we were just naturally helping before our training. Together with the Health Department, we hope to see the impact of our work in fewer infant deaths and low birth weights, more people using the available health services, and more people knowing how to live and eat to take care of their health. We also hope to show that the involvement of local people in partnership with the health agencies can begin to get at the roots of some of our biggest health problems.

To conclude, I would just like to thank you for taking the time to work on this bill for the Nation. As health advisors, we are not seeking recognition for our effort, but health is one of the most important things you are working on up here in Washington, because good health gives every American the chance for a full and happy life. Without good health, a person doesn't have a chance.

I do want you to know that you are not alone, and the Public Health Service and the State Health Departments are not alone in this struggle. There are people in every community in this Nation who are concerned about the health of their community and looking for a way to do something about it. We are ready to join you and the health professions as partners for a healthy Nation through healthy neighborhoods. It is important for policy makers to understand that local initiatives to the problems of poor health and poverty have the best chance of producing lasting solutions.

Thank you again for listening to what I have had to say, and may God bless you.

Senator HARKIN. Herrestine, thank you very much for a very fine statement. It sounds like a very innovative program, and just points out again it pays to have flexibility to get local people involved and to use their own ingenuity. They can go to work. It is a great statement.

Senator HARKIN. Emily Holing, from Bellevue, WA, and your daughter, Erin. Welcome Erin.

Ms. HOLING. Thank you. I appreciate the opportunity to be here to talk about diabetes and pregnancy and the prevention of birth defects. I have had insulin-dependent diabetes since I was 10 years old, and, therefore, I will speak first from a personal perspective.

It is a fact that women with diabetes have a 3 to 5 times greater chance of having a child with a major birth defect than a nondiabetic woman. These birth defects most commonly involve the heart or the neural tube, such as spina bifida or malformations of the brain.

As I grew up and reached adulthood, very much wanting children, these were the statistics I read about. I talked to numerous physicians, and they all told me the same thing: basically, that I should not become pregnant. At the time, it made me hate having diabetes.

In 1981, actually by chance, I saw a flyer in a hospital elevator that Dr. Zane Brown, who is a perinatologist at the University of Washington, was giving a talk on diabetes in pregnancy. He was the principal investigator of a large multicenter NIH research grant project called the Diabetes in Early Pregnancy Project, and he believed that women with diabetes could have health pregnancies. The question of the research project, and obviously for me personally, is: If diabetic women can keep their blood sugars well controlled from the time of conception onward, is their chance of birth defects reduced?

I enrolled in the study. I learned that to minimize my risks, I needed to have excellent diabetes control before I became pregnant. I actually thought I was doing fairly well at the time with my diabetes, but I learned that I had quite a ways to go. The goal during a diabetic pregnancy is to keep blood sugar levels normal, the same as a nondiabetic. This is actually no easy undertaking. There are many factors that can throw blood sugars off balance. You have to pay attention to everything you eat. Even half an orange can send blood sugars too high. Stress can send your blood sugars high. Mine are probably high today. You take at least 3 insulin injections each day. You monitor your blood sugars throughout the day to find out how these factors are balancing. This involves poking your fingers for blood to check your own blood sugar at home, and you do that eight times a day throughout the pregnancy, including 3:00 o'clock in the morning. There is obviously frequent physician visits and testing, etc.

I brought my blood sugars under good control before I became pregnant, and then I did get pregnant. Nine months later, my daughter Erin was born—she is here today—perfectly normally and healthy.

Senator HARKIN. And very pretty.

Ms. HOLING. And probably more perfect today.

Two years later, I had another healthy pregnancy, and my son Zachary was born. He is 5 today. He behaves very much like a normal 5-year-old. That is why he is not here today. [Laughter.]

The question then, can diabetic women have healthy pregnancies, the answer for me and for thousands of other women would be: The Diabetes in Early Pregnancy Project has shown—and it has been confirmed by studies in Europe—that if women maintain good blood sugar control throughout pregnancy, their malformation rate is reduced to nearly nondiabetic levels.

This has been a well-known medical fact for over 5 years. We know what causes birth defects. We know how to prevent them. And the question remains: Why are they still so high?

The answer is that our health care interventions are too late. Birth defects happen very, very early in pregnancy. The heart is formed within 6 weeks, and the brain and neural tube are formed within 5 weeks. This is before most women even know that they are pregnant. So by the time of their first obstetrician visit, it is already too late.

I currently work as a nurse practitioner and coordinate the diabetes and pregnancy program at the University of Washington in Seattle. We do an excellent job of managing high-risk pregnancies. We can save premature babies that are born 3 months early. We have sophisticated neonatal intensive care units. But we do not do an adequate job of providing women with the education and tools they need to prevent the birth defect from happening at all. By the time most women are referred to our program, it is already too late.

We need funds for community, professional, and patient education programs to teach about diabetes in pregnancy and how to prevent these birth defects. Women of childbearing age need to hear again and again and again how to prevent birth defects, how to plan their pregnancies.

I know that no one wants to put a price tag on a healthy child, but this pre-pregnancy planning program is a fine example of saving money in our health care system. The State of California just assessed the cost for hospitalization of a child with malformation at \$35,000 and the medical costs for that child to the age of 20 at \$250,000. Obviously, the cost of pre-pregnancy counseling and care is much smaller, and yet it is not funded by our current welfare system. Many insurance companies will not reimburse for diabetes education or for equipment needed to monitor blood sugar. Washington State's Medicaid program will pay approximately \$100 to \$150 for a blood sugar monitor after a woman is pregnant, but not before. Again, it is too late.

In the work that I do with the Diabetes in Pregnancy program, I am thankful for every opportunity I have to teach women before they become pregnant. Unfortunately, these women are still the exception. The hardest part of my job is the women I see who come in who are already 6 to 8 weeks pregnant. They are very excited about being pregnant, but if their control has been poor, I know that they have a high risk of having a child with a hole in his heart or less than a complete brain. I have to explain these risks to this woman and to her partner. Then when I go home at night to my own healthy children, I know that it could have been very dif-

ferent for me. I would like to see every woman have the chance I had and every child have the best chance to be born healthy.

Thank you.

[The prepared statement of Ms. Holing follows:]

PREPARED STATEMENT OF EMILY HOLING

My name is Emily Holing. I have had insulin dependent diabetes since the age of 10. I will first speak to you today about diabetes in pregnancy from a personal perspective.

Fact: Women with diabetes are 3-5 times more likely than the non-diabetic woman to have a baby with a major birth defect. The most common defects are cardiac related and those involving the neural tube, such as spina bifida and malformations of the brain. This is a grim statistic.

As I reached adulthood, very much wanting children, these were the statistics I read about. I asked numerous doctors, who told me I should never become pregnant. It made me hate this disease.

In 1981, by chance, I saw a flyer in a hospital elevator. Dr. Zane Brown, professor and perinatologist at the University of Washington, would be lecturing on diabetes in pregnancy. He was a principal investigator of the D.I.E.P. (Diabetes in Early Pregnancy) Project, a large multi-center NIH study, which looked at the relationship between the diabetic mother's blood sugar control in early pregnancy and fetal outcomes.

The essential question, for me personally, and for thousands of diabetic women and their families: If a woman's diabetes is in good control at the time of conception and throughout the pregnancy, is the chance of birth defects in her baby reduced?

I enrolled in the study. I received education and counseling about the potential risks of a diabetic pregnancy as well as the financial and emotional demands. I learned that to minimize my risks I would need to follow intensive diabetes control. I actually thought at the time that I was already doing fairly well with my diabetes, but I learned I had a long way to go. The goal for the diabetic pregnancy is to achieve normal or near normal blood sugar values. This is no easy undertaking. In fact, few insulin requiring diabetics maintain this type of diabetes control during their non-pregnant years. It requires careful attention to everything you eat. An extra orange can send your blood sugar too high. It requires three or more insulin injections each day. It requires poking the end of your finger to check your blood sugar eight times each day, including 3 a.m. You learn how to adjust your own insulin on a day to day basis and deal with more frequent low blood sugar reactions. Along with all of this is coping with the anxiety and your spouse's anxiety about whether the baby will be healthy.

I waited until my blood sugars were well controlled and then became pregnant. Thirty-seven weeks later, my daughter Erin was born, perfectly normal, perfectly healthy. She's here with me today. Two years later, I had another healthy pregnancy, my son Zachary, who is 5 years old.

Can birth defects be reduced if diabetic women maintain good blood sugar control in pregnancy? My answer was YES. It has been shown by the Diabetes in Early Pregnancy Project, and confirmed by studies in Europe, that the congenital malformation rate in the babies of mothers with excellent blood sugar control throughout early pregnancy is reduced nearly to that of non-diabetic women. In contrast, women in very poor control during the critical early weeks may have a 50% or greater chance of bearing a child with a major malformation.

This has been a well known medical fact for over 5 years. We know what causes birth defects. We know how to reduce them. So why is the malformation rate for diabetic pregnancies still so high?

The answer is, our health care interventions are too late. Birth defects happen very very early in pregnancy. The brain and neural tube are formed within 5 weeks of pregnancy, the heart within 6. This is before most women even know they are pregnant. By the time of their first OB appointment, the damage has been done. It's too late.

I currently work with Dr. Zane Brown as a nurse practitioner, coordinating the diabetes and pregnancy project at the University of Washington in Seattle.

We do an excellent job of managing high risk pregnancies. We can save premature babies that are born 3 months early. We have sophisticated neonatal intensive care units. But we are not adequately providing diabetic women with the education and tools before they are pregnant to prevent the birth defect from happening at all. Each week women are referred into our program who are already pregnant. The majority of them have never heard that good blood sugar control from conception prevents birth defects. By the time they reach us, it's too late.

What is needed? Funds, available through state block grants or other vehicles, to support the Year 2000 Objectives on diabetes and pregnancy. Professional, community and patient education about diabetes in pregnancy is needed to demonstrate how birth defects can be prevented. Every diabetic woman of childbearing age needs to hear again and again and again the message on prepregnancy planning. When they do come into our health care system for prepregnancy care, we need to be able to provide that education and care.

I described earlier a fairly tedious management regimen diabetics must follow for intensive diabetes management. You might ask, how many women are able and willing to do this? How many will poke their fingers eight times a day? The vast majority of women we work with, given the knowledge, the tools and the support are successful. Our maternal instinct to protect our child is very powerful. If the pregnancy is desired, most women can, and will, do whatever they need to do. This is true across social, racial,

and economic lines. Women come into our program who throughout their lives may have neglected their own diabetes care, and yet when they learn what they must do to protect the health of their baby, they will do it.

No price tag can be placed on a healthy child. Yet we know that social programs are expensive, and "fiscal responsibility" is a fact of life. The good news is that the programs needed for diabetes in pregnancy can save health care dollars. Statistics from the state of California assessed the price of the neonatal hospitalization of an infant with a major congenital malformation at \$35,000, and the cost of raising that child to the age of 20 at \$250,000. Compared to this, the cost of preconceptual care is very small indeed, yet it remains unfunded by our current welfare system. Many insurance companies will not reimburse for blood glucose monitoring supplies and/or diabetes education. The Medicaid program in Washington state will pay the \$150 for a blood glucose monitoring meter after the woman is pregnant, but not before. Again, it's too late.

In the work I currently do with the Diabetes in Pregnancy program at the University of Washington, I relish each opportunity to teach women BEFORE they become pregnant. Unfortunately, meeting diabetic women before pregnancy is the exception. The most difficult part of my job is each woman I must counsel who comes in already 6 or 8 weeks pregnant. If her blood sugar control is poor I will talk with her, knowing that there is a very high chance that if she carries the pregnancy, her baby will be born with a hole in his heart, or with spina bifida, or with less than a brain. I have to explain these risks to her and her partner. I go home to my own two healthy children, knowing how different it could have been for us. Every diabetic woman deserves the chance I had. Every child deserves the best chance to be born healthy.

Emily Holing, ARNP, MN, CDE

Senator HARKIN. Thank you for being here today. Erin is 7?

Ms. HOLING. Yes.

Senator HARKIN. Did you fly here all the way from Washington, Erin? You got out of school.

Ms. HOLING. Yes. She's playing hooky. [Laughter.]

Senator HARKIN. Well, thank you all very much.

Reverend Brooks, Mrs. Brooks, again, tell me, how did this happen? How did you happen to get this screening in your church? Did they come to you? Did you go to them? How did this all come about?

Rev. BROOKS. We had a very progressive public health nurse, and I was chairman of the Lyon County Health Council, and that is made up of volunteer people of about 2 dozen people from many walks of life. We are known in the community to try to coordinate efforts to bring about better health. The public health nurse wanted to write for this grant for this Federally funded screening clinic. One of the requirements was that there had to be a facility where this could be held gratis. So when she made this report, I told her I was sure that I could twist my board members' arms to make our church available, and that is what happened. It is still being carried on there.

Senator HARKIN. At the church?

Rev. BROOKS. Yes, right.

Senator HARKIN. On what, a weekly, monthly basis?

Rev. BROOKS. It is on a quarterly. There are four of them scheduled in Lyon County, and they rotate. So they come every quarter to the designated town. The nice part about our church, it is handicap available, and the room just really lends itself, very professional, private, the whole bit. It is just a nice arrangement.

Senator HARKIN. Just one nurse comes?

Rev. BROOKS. Two nurses. As I say, one is maybe going through the physical examination and the lab work while the other is doing the interviewing. The interviewing is at some length. It is a very careful interview. So it is very efficiently run as well as very professionally being run.

Senator HARKIN. Both of you have a very happy ending to your story.

Rev. BROOKS. Yes, very much so.

Senator HARKIN. Before you got that health screening, when was the last time you had gotten any kind of—

Rev. BROOKS. I was afraid you were going to ask me that. A professional person should know better, but I don't like to go to doctors. So I simply didn't. I felt healthy. You know, if that is going to happen to me, it is going to happen to a lot of other people. They find it so easy just to go. They know these nurses. They are friendly. Not that the doctors aren't, but there is just a different feeling. They have more time. The doctors are very busy with their surgeries. They give you the impression they are very interested in you, and they will take all the time to listen. Then it makes you motivated to listen to what they have to say as well. They give a lot of good educational health tips, as my friend down here talked about her work. They educate the people on better health and better diet and better exercise programs, that type of thing.

Senator HARKIN. So it had been some time that you had had a health screening before. You never really answered that question.

Rev. BROOKS. Well, probably 3 or 4 years.

Senator HARKIN. Well, again, just living proof of what it means to have good checkups and physicals.

Rev. BROOKS. Yes.

Senator HARKIN. There is really no provision for that kind of payment to be made, is there? Medicare won't pay for that, and Medicaid won't. That just points out why—

Rev. BROOKS. I confess it was more of an emotional thing than an economic thing. That just says something about me, but confession is good for the soul so here I am.

Senator HARKIN. Yes, and we appreciate your being here.

I would defer to Senator Cochran either for the Brooks' or Herrestine.

Senator COCHRAN. Mr. Chairman, thank you. I just want to thank everybody who is here today helping acquaint us with some personal experiences that all of you have had which help us understand the importance of having a health initiative for preventive health care and screening. Spending some of our resources on trying to make people aware of things they can do for themselves to help improve their health situation, and how cost effective it is to spend money at that stage. I appreciate Ms. Holing's comments about how there aren't available resources from the Government to help support some of these early detection efforts or screening, and how that needs to be looked at. And Ms. Chambers very eloquently in her statement, I think, talked about a neighborhood-based program and how it can really engage in outreach and come in contact with people and acquaint them with things that they would never have an opportunity to know, and programs that they would never have an opportunity to enjoy if it weren't for a neighborhood-based program like PINAH in the Mississippi Delta.

Mr. Chairman, the other day I read—and I don't know whether this is an accurate figure or not—that 25 percent of the expense of health care in America today is spent on those who are in the last 6 weeks of their lives. And if you think about that in dollar terms and then probably compare it with the amount that is spent on preventive health measures and the things that were described by our witness panel today, I would guess that it would be 2 percent. I may be off. But we have got this upside down in our country today. We are allocating huge amounts of money, I know in a caring way, in an effort to deal with inevitability and horrors of the last few weeks or moments of life. But I really think we need to emphasize more the early detection, prevention of illness and sickness. That is where we are going to get the biggest payoff in terms of helping to see that people enjoy a full and rich and longer life.

I am not saying that we ought not to spend anything, you know, at the other end of the cycle. But I just think that we have got the emphasis economically turned upside down. And I don't know how we fix that, but we are working on it here in this committee. Anybody who has some suggestions for us, we would welcome them. This initiative that Senator Harkin is pushing and that I am interested in helping to enact, the Health Objectives 2000 Act is a start, is a step in that direction, I think.

I hope you can encourage your Congressmen and Senators that you know to help us get this passed, because I think it will do a lot to help people all over the country—the Mississippi Delta, the State of Washington, South Dakota and Iowa and all the places in between. Your testimony has really been very enlightening and very helpful to us as we try to do something about this problem.

Thank you all for being here.

Senator HARKIN. Thank you. I just wanted to ask Herrestine, you are doing something down there in outreach and helping people. How did you become a health advisor? I didn't really quite understand how you became a health advisor.

Ms. CHAMBERS. I was always helping people in my community, so my name just was brought up. I was the one that always helped. We started as Christian women helping the community. So after PINAH came to town, my name was somewhere at the top of the list. I got in touch with them, and I began to take the course. As Christian women, we went about doing this, but we were somewhat not on the right track. So after PINAH got there, it helped us get us started. Now we can reach places in the rural, isolated area that haven't been reached before.

I also want to let you know that I can identify with what you were saying about the health department used to come in the field and give the people shots. I was one of those children.

Senator HARKIN. Yes, the public nurse would come around and give you shots.

Ms. CHAMBERS. But they are not doing it.

Senator HARKIN. They don't do it any more. I don't know if you were here when I was talking about that, Thad. I grew up in a small town of 150 people. Anyway, right after World War II, I must have realized probably in 1st grade, I remember that is the first time that the public health nurse came around and lined up all the kids and we got our shots. We got our smallpox vaccination, and we got measles, I don't know, whatever it was that we got. I remember I was scared. I still remember getting those shots. Then every morning we had to line up and get our glass of fruit juice. Every morning, we had to come in school, we would line up, and the nurse would come around and ride the circuit, come to the school about once a month and talk about brushing our teeth, washing our face and hands and all the things that you are supposed to do, and then getting these shots. And I heard the other day that there is something like 10 million kids in America under the age of 10 that never had a shot for measles or smallpox or whopping cough. So I don't know what is going on out there. I thought we were still doing it like I remember it when I was a kid. But evidently it is not being done through the public health organizations.

Ms. CHAMBERS. Well, I think, sir, it is because of the funds.

Senator HARKIN. But, you know, another thing that you point up, Herrestine, is the—how can I say this? You don't always need an M.D. out there to help people in their health problems. People with just a little bit of training, a little bit of support, it is amazing what they can do. I am sure you aware of it. We had this nutrition education program that has been in the Department of Agriculture for years and years. I don't know how many sites you have in Mis-

Mississippi. We have maybe 10 or 12 in Iowa, I guess. The people just go out on their own. They are training a little bit to help low-income people learn how to prepare nutritious meals. It has been in existence I think 25 years now.

Ms. CHAMBERS. The County Assistance Service still does it.

Senator HARKIN. You do have that. Great program. And what happens is the people that learn, they go on and teach other people. Well, it is the same kind of thing here, you see. Get people involved that aren't necessarily M.D.'s and all that, it makes a tremendous difference. It is a good example.

Well, Erin, are you anxious to get back to school? I am sure you are, right? [Laughter.] Did you get to see some of the monuments and things like that?

Miss Holing. Yes.

Senator HARKIN. Yes? Good. You are a very pretty and obviously very healthy young lady. We are glad you are here.

Thank you all very much.

Senator HARKIN. Our last panel is H. Denman Scott, M.D., president, Association of State and Territorial Health Officials. His testimony is presented by Dr. Earl Fox, Director of Health in Alabama and a member of ASTHO. Also, Dr. William Keck, president-elect of the American Public Health Association, from Akron, OH; Dr. Wasserman, president of the National Association of County Health Officers, and Director of Health, Montgomery County, MD. His testimony will be presented by Suzanne Muncy, Deputy Director of Health in Montgomery County. And Dr. Jane Delgado, president of the National Coalition of Hispanic Health and Human Services Organizations.

We will start with Dr. Fox. I understand you have to catch a plane at noon. You are on. Welcome, and I understand Dr. Scott is ill, so we are glad to have you here.

STATEMENTS OF EARL FOX, M.D., DIRECTOR OF HEALTH, ALABAMA, AND MEMBER, ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS (ASTHO); C. WILLIAM KECK, M.D., M.P.H., PRESIDENT-ELECT, AMERICAN PUBLIC HEALTH ASSOCIATION (APHA), AND DIRECTOR, DEPARTMENT OF HEALTH, AKRON, OH; SUZANNE MUNCY, NATIONAL ASSOCIATION OF COUNTY HEALTH OFFICIALS, AND DEPUTY DIRECTOR OF HEALTH, MONTGOMERY COUNTY; AND JANE DELGADO, Ph.D., PRESIDENT, NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS (COSSMHO)

Dr. Fox. Thank you, Senator. I am real pleased to be here representing the Association of State and Territorial Health Officials. I am the Commissioner of Health in Alabama. I am a pediatrician, and after all the comments about M.D.'s, I was a little bit hesitant to testify. Nevertheless, I will plow on.

Senator HARKIN. You need the M.D.'s after that initial screening.

Dr. Fox. That is right, exactly.

I cut my public health teeth in the Mississippi Delta, having grown up there, and I have been in public health for 17 years. I started out working at the local level, and I guess just to point out that hopefully I still have some sense of reality about what the

local needs are, I still work in public health clinics. I go out and do home visits with the nurses, provide DD care, see disabled patients at least one to four days a month. So I try to keep some touch with what is going on out there.

ASTHO strongly supports both the national health objectives act for the year 2000 and the health objectives as stated as a back-up to the funding for that act. We see the national health objectives act itself as a major step and a major key in achieving those objectives. We believe the act is an appropriate measure to address the concerns raised by the Institute of Medicine in "The Future of Public Health" around adequate funding for public health, adequate information on which to make decisions, and the need for additional services. We know that although only about 50 percent of the 1990 objectives were achieved, I personally believe that many more of those objectives could have been achieved with the type of support that we are talking about here with the Senate Bill 2056. I would like to commend you, Senator Cochran and others for the support that you are providing to this bill.

I want to say that one of my major frustrations as a public health professional for 17 years has been working out in public health services and seeing the unmet needs, which I hope I can relate a few of those to you today, and the inability to meet them basically through lack of additional funding.

Why is the national health objectives act important? Well, I think there are several reasons, and the first and most obvious is the funding. It has already been stated in the comment about 2 percent of the expenditures was right on mark. We estimate that out of about \$500 billion spent every year in this country on acute care, that only about \$10 billion at the absolute most is spent on prevention. And I think that is probably a high estimate. We know that over the last decade State funding for public health has risen, when adjusted for inflation, about 56 percent. So States are doing their share in trying to support public health. In Alabama, we have had about a hundred percent funding in the last four year increase. We know that when we adjust for WIC—and WIC's have been increased every year, and that is great, I think in large part to efforts like Senator Cochran and others who have strongly supported that program. But when you take WIC out, the Federal funding for preventive services overall has been flat when adjusted for inflation over the last 10 years. I think all of you know what the costs have done for providing health care services.

Senate bill 2056 would provide \$300 million additional money, which although it is only a 2-percent increase in public health funding, I think it would be key in helping us achieve these objectives.

Why should we fund prevention? Well, I don't think I can make any better argument than those that have already been made here today, but I would like to just State two or three if I could. We do know, one, that prevention is cost effective. The Institute of Medicine has already stated that for every dollar spent on prenatal care, that \$3.38 is saved in short-term costs. We know that for every dollar spent on immunization we save \$10. We know that if we treat a person for high blood pressure and we spent \$50 or \$100, we can save, in addition to the cost of the bypass surgery that has

already been mentioned, Senator, Medicare currently pays a minimum of \$20,000 per year for kidney dialysis for people who have end stage kidney disease and have to be dialyzed. That is a recurring amount every year and a cost that we could save.

We know that it can improve the quality of life if you look at someone with emphysema who has to have an oxygen tank, cannot make it across the room because of the fact that they can't get their breath. That certainly could be prevented. We know that strokes from high blood pressure can be prevented. Two months ago, I saw a 45-year-old black man who had been working in a factory, employed, paying taxes, independent, who had high blood pressure, could not afford the medication, had a stroke, and when I saw him, he was in a wheelchair. He had total paralysis on one side, and he could not speak, and he will never be able to take care of himself again. Now, that gentleman is not going to be able to work and support his family. He is going to be a dependent at a huge cost to both his family and society, and all of that could have been prevented for \$30 to \$50 a year in blood pressure medicine.

We know that it saves lives. If you look at motor vehicle accidents, in this country the leading cause of death after age 1 is accidents, motor vehicle accidents. And we could prevent that. Education does work. We have seen a decline in deaths and an increase in seat belt usage just through education thus far, but we could do more. So funding is important.

The other is we need a data base, and this bill provides for that. We do not have the information on which to make rational decisions in this country. This provides dollars to establish both a data base and also some data indicators to help us look at what is actually happening. And we don't have that right now. I think that would be key in trying to look at where we are going and how we are going to get there.

It provides core objectives. The Secretary would establish core objectives through an advisory committee to help us have at least some common elements that we are all working toward in the 50 States. But then it also provides for some flexibility, and there are different needs in different States. Some States may need to do a lot in prenatal care. Other States may need to do a lot in injury prevention or in high blood pressure control. And if there is one thing I have learned being on the executive committee of the State Health Officials Association, is that every State is different. So we have to allow some flexibility, allow the States the ability to fund those priorities in the individual States.

There are a few suggested changes that we would respectfully like to add, if we could, regarding this bill. One is proposed language to create in each State a Health Objectives 2000 advisory committee that would be appointed by the State health official. The composition would be members from the general public, and this group would be instrumental in helping the State to look at the State priorities and decide how the objectives are going to be met within the individual State. We also would like to recommend that the Centers for Disease Control be designated as the institute responsible to establish the common data sets and the data that is going to be needed to look at each objective, and that each State be required to report on these data sets so that we have some common

data across all States. Third, that the composition of the National Advisory Committee to which you have already alluded would be increased by one member to include a representative from the American Public Health Association. We think that is very important. Fourth, there is some concern regarding the phase-out of the preventive block grant, and I would just like to say that there is a need for increased funding. And one of the reasons that we feel that we can just not phase out the block grant and phase in the national health objectives act without being careful is because the national health objectives act does require some things that are now not required, such as the information, the data, the reporting, the new projects, the programs that are going to be done that are not being carried out now. So we feel that that needs to be looked at.

So because of that, what we would like to suggest would be three steps in the allotments to the States under this act. First, that in Section 1943, that the first \$85 million—which is the amount currently appropriated for the preventive block grant—be allocated basically as the preventive block grant is being allocated in fiscal year 1990. The second, that the next \$50 million, up to \$135 million total, be allocated to each State on a formula that we would like to provide the staff some additional information on after the hearing. That would go for new core support for assessment, policy development, and new programs. Then, finally, that all moneys over \$135 million be allocated to States on a per-capita basis. So this would ensure some base funding. It would ensure that no one is hurt in getting less funding than they currently get under the preventive block grant, but it also, we feel, would be an equitable way to divide additional money.

Finally, let me say, as a public health professional, I find it contradictory that we as a Nation should spend so little and give so little priority to prevention when we complain so loudly about our health care costs and the cost of end stage disease care. I would also be concerned that we tout the health objectives for the year 2000 so loudly and at the same time that we would seriously consider not providing additional financial support by which we could achieve these objectives.

Because of these concerns, we in ASTHO believe that Senate Bill 2056 is nothing less than the cornerstone by which we can ultimately ensure a healthier America and achieve a more productive society. We commend each one of you on your support for this act. Thank you.

[The prepared statement of Dr. Scott follows:]

PREPARED STATEMENT OF H. DENMAN SCOTT

Good Morning, Mr. Chairman, Members of the Committee. My name is H. Denman Scott, I am Director of the Rhode Island Department of Health, and I am currently serving as President of the Association of State and Territorial Health Officials. I appreciate the opportunity to testify before you today on S. 2056, The Health Objectives 2000 Act.

ASTHO wholeheartedly supports the nation's commitment to defining Health Objectives for the Year 2000, and applauds S. 2056 because it will augment our resources needed to progress towards the Objectives. We are especially pleased that Senator Harkin has taken the lead in sponsoring this bill and that there is such a distinguished list of co-sponsors, including Senators Hatch and Kennedy as well as both Senators Pell and Chafee from my home state.

During the past few years, several things have occurred which have brought to light the need for the United States to review the means for improving its citizens' health. We have directed huge resources for high tech medical care which, coupled to a rapidly aging population, has produced unremitting rises in

health care costs. While many benefits have accrued from these expenditures, rising costs have also contributed to a rapid expansion in the number of people without health insurance.

The twin problems of cost and access have made it difficult for the nation to focus on its health goals and how an expanded commitment to health promotion and disease prevention can contribute to our reaching those goals.

Passage of S. 2056 will go a long way towards correcting the imbalance between medical care and health promotion and disease prevention; between our obsession with how we get out of trouble, rather than how we stay out of trouble.

Another important occurrence has been the release of the Institute of Medicine's report on "The Future of Public Health." The report was originally commissioned to address a growing perception that this nation has lost sight of its public health goals. It contains a strong message calling for increased national funding to encourage states and localities to address specific health objectives. The IOM report places a high priority on the importance of policy development in public health. It states that both the National Objectives for 1990 and the upcoming Year 2000 Objectives, as well as the model standards for community preventive health services, constitute this nation's public health policy. According to the IOM, national funding for state and local efforts to address these national objectives is needed.

One of the most important challenges we face is translating the Year 2000 Objectives from the national level to the state and local levels in clear, straightforward, and effective ways. The objectives for the nation are constructed in a very logical fashion. What is needed is a pragmatic process to link state and local efforts to the objectives. The state health departments, in partnership with local agencies, are in a position to translate the objectives into action.

The Year 2000 Objectives are a coherent set of national health objectives -- the kind of public health policy which the IOM report says states should be addressing, but for which they lack adequate funding. This nation desperately needs a commitment of new federal funding specifically earmarked for attainment of the Year 2000 Objectives at the state and local levels. A prime example of the need for increased funding is the 1990 Health Objectives. While approximately 50 percent of the objectives were obtained, many more could have been reached if funding was available.

The National Health Objectives can increase interagency and intergovernmental cooperation, and provide a lasting health promotion and disease prevention strategy that can continue to capture public interest over time. For the Department of Health and Human Services to establish Year 2000 Objectives without providing resources to assist in their attainment, is to engage in an academic exercise without promise of fulfillment. Thus, we commend the Senate for its leadership in designing S. 2056 and

providing an authorization with funding which will help assure actual attainment of the objectives.

The Health Objectives 2000 Act, S. 2056, represents the first important step toward realizing the Year 2000 Objectives and a healthy nation. The bill will provide funding to state health agencies to build capacity and resources to achieve the objectives. It will create and develop a partnership between federal, state and local health agencies, and other groups aimed at developing initiatives in preventing diseases and illness. The bill will also enable states and localities to address national health policy issues and assess the health status of the population. Each of these provisions is a necessary component in improving the health status of this nation.

The Health Objectives 2000 Act will allow states to develop their own state specific programs based on the needs of their residents. This flexibility is vital so that the priorities unique to each state may become the focus of attention.

For example, the states of Rhode Island and Alabama prepared simulations of what they would do with new funding under the Health Objectives 2000 Act. With regard to smoking, Rhode Island would work toward implementing comprehensive school health education programs, school smoking policies, school-based risk assessment/risk reduction programs, tobacco and alcohol taxes, and low income minority tobacco prevention initiatives. Alabama would choose to develop a media campaign to address the dangers of tobacco use, would work toward a statewide Clean Indoor Air

Act, train one member in each county health department as a smoking cessation facilitator, and would provide smoking cessation programs to all interested pregnant women. With regard to unintentional injuries, Rhode Island would place its emphasis on seat belt usage while Alabama would develop a CPR training and water safety program, as well as a program encouraging the use of bicycle helmets. Rhode Island would use funds to establish a substance abuse surveillance system, but Alabama would implement an aggressive program to provide grants to local community mental health centers in an effort to increase their capacities in working with adolescent drug abusers, and create new comprehensive day treatment and residential treatment programs for pregnant women.

S. 2056 gives the states the flexibility to address the more pressing issues within their jurisdictions. This flexibility is terribly important. In addition, states will focus in on core health priorities selected by the Secretary and the National Advisory Council. The bill is broad enough then to provide support for state activity addressed to the 21 national health objectives being established by the Department of Health and Human Services.

ASTHO believes this legislation is a major milestone in health policy, and after much discussion with its members we would like to offer the following suggestions for changes in the bill which we believe would make it stronger. ASTHO proposes the inclusion of additional language to create within each state a

Health Objectives 2000 Advisory Committee to be appointed by the state health official. The Advisory Committee would advise and make recommendations to the state health official regarding the selection of state health priorities and the implementation of the Act.

In regard to uniform data collection, a very important element of this new program, ASTHO would recommend that language be added to the bill providing that the Centers for Disease Control establish common data sets for each objective. ASTHO would also recommend that each state be required to report on these data sets for objectives in its state plan thus contributing toward a national overview on the health status of this nation.

ASTHO would also recommend that the composition of the National Advisory Committee be expanded to ten members, and that the American Public Health Association be represented by one appointee on the Committee.

Finally, in discussing the formula for funding under S.2056, there has been some concern expressed by states that to phase out the prevention block grant and replace it with the Health Objectives 2000 Act may cause severe disruption in funding to some state agencies. States are enthusiastic over additional program responsibility and reporting requirements on the basis that there will be a significant increase in funding for prevention services. Since S.2056 establishes a new program for assistance to state and local agencies to primarily initiate new programs of prevention services and to enhance data collection

and reporting on outcomes of such interventions, ASTHO recommends that the allotments to states be revised into three distinct steps. The first step of Section 1943 of the Bill should be revised to allocate the first \$85 million in proportion to the states' allotment under the Prevention Health and Health Services Block Grant distribution in Fiscal Year 1990. ASTHO then proposes that for step two, each state share in the allocation of the next \$50 million up to \$135 million by a schedule which will provide proportional distribution of funds to states for new core support for assessment, policy development, data collection and reporting, and to initiate new programs. We propose that as step three, all funds beyond \$135 million be allocated on a per capita basis to each state in proportion to the total U.S. population for the expansion of services and programs designed to meet the state health objectives.

The 1989 Public Health Chartbook, which was compiled by the Public Health Foundation, displays a number of facts which are critical to the viability of public health.

First, it is interesting to note that 40 percent of local health department expenditures are received from state health agencies by way of intergovernmental transfers (Figure 4). This illustrates the importance of state health agency funding to the maintenance of local public health activities.

Second, it is noteworthy that state tax and fee revenue represent 57 percent of state health agency and local health department expenditures combined. Whereas, federal funds

represent only 28 percent of state health agency and local health department expenditures combined. Further, local funds represent only 14 percent of state health agency and local health department expenditures combined (Figure 5). Therefore, it is clear that the states are currently carrying the bulk of the burden for financing state and local public health activities.

Next, it is important to note that while total state health agency expenditures have been increasing over the last decade, there has been only a very modest increase in state health agency expenditures on an inflation-adjusted basis. Further, when USDA (WIC) expenditures are excluded, state health agency expenditures have practically not changed at all on an inflation-adjusted basis over the last decade (Figure 9).

Over the last decade the states have expanded their commitment to public health funding. Adjusted for inflation (1977 dollars), the state's commitment has grown from about \$1.6 billion to \$2.5 billion, an increase of 56 percent. Excluding WIC funds, other federal public health funding decreased from about \$0.7 billion to \$0.6 billion, a decline of 14 percent (Figure 10).

In 1987 the public health agencies of the states and the localities spent \$10.3 billion (1987 dollars). This sum is quite modest in comparison to the \$500 billion spent on health care in 1987.

S. 2056 calls for an authorization of \$300 million. In 1990 this will boost the public health effort a little more than two

percent. Surely the bill is not asking for a lot. But it is asking for enough to give public health a significant boost.

In evaluating the need for this legislation it is important for Congress to consider three things -- prevention saves lives, prevention improves the quality of life, and prevention saves dollars in certain circumstances. Prevention must become a key word in the 1990's with regard to the health of this nation.

During the past century, through medical research and historic discoveries, we have substantially decreased, and in some cases eradicated, the leading causes of death which plagued this nation early in this century. Modern medicine has allowed us to properly treat, and in fact cure, many ailments which in the past would have left people dead, incapacitated, and disabled. With these cures has come a new list of leading causes of death. Of the ten leading causes of death, almost all are preventable or can be treated effectively for many years after early detection and intervention. Many are directly related to individual lifestyle. These leading causes of death include: heart disease, malignant neoplasms, cerebrovascular disease, unintentional injuries, chronic obstructive pulmonary disease, pneumonia/influenza, suicide/homicide, diabetes mellitus, chronic liver disease and cirrhosis, and AIDS.

How does prevention save money? In many ways. For example, about \$10 in subsequent medical costs is saved for every dollar spent on childhood immunizations, including German measles, Polio, Diphtheria, Tetanus, and Whooping cough. \$3.38 in savings

is generated for each dollar spent on prenatal health related care for low income pregnant women. Estimates have indicated that investments in prevention can produce reductions in the incidence of teenage pregnancy, auto injuries, and the need for alcoholism treatment, resulting in a net savings of roughly \$480 billion. Prevention programs work.

A key area where early prevention measures are successful is breast and cervical cancer screening. Breast cancer is the most common cancer in women. In 1985, breast cancer accounted for 40,383 deaths and \$5.165 million in mortality costs. One in 11 women will develop breast cancer during her lifetime. Uterine cancer accounted for another 4,500 deaths. 12.5 funerals per day is a lot, and every one could have been prevented. For both cancers, early detection is the key to cure. A large proportion of women whose breast cancer is diagnosed early will be cured. Virtually all women whose breast cancer is diagnosed late will be dead within five years. Cervical cancer detected early is almost 100% curable.

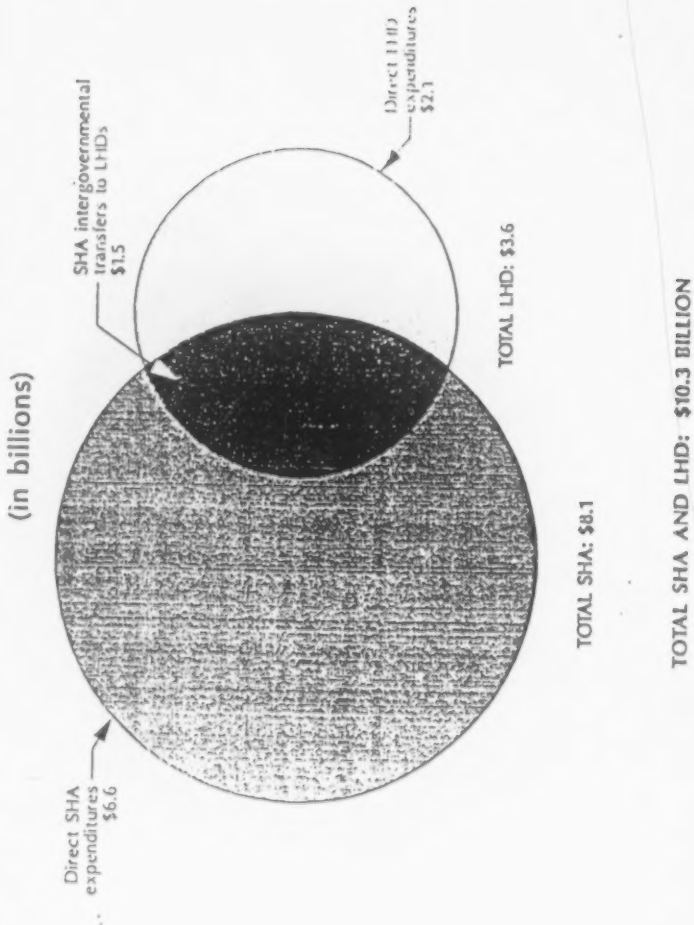
Improvement in the health of the U.S. citizens will be achieved not primarily through increased medical care and greater health service expenditures, but through a renewed national commitment to prevent disease and to promote health.

Our biomedical research efforts are the envy of the world and now as a nation we need to make a similar concerted effort to make available to the citizens of our nation the fruits of preventive research. The techniques for primary prevention,

screening, and early intervention have been developed in many areas. Now we need the resources to get this technology off the shelf and into practice in every community throughout the nation. S. 2056 provides further direction in this area by focusing needed resources into state and local-based prevention programs.

Thank you. I am available for any questions you may have.

FIGURE 4.
STATE HEALTH AGENCY AND LOCAL HEALTH DEPARTMENT EXPENDITURES,
BY TYPE OF EXPENDITURE, FISCAL YEAR 1987



Source: PUBLIC HEALTH FOUNDATION

May 1989

FIGURE 5.
STATE HEALTH AGENCY AND LOCAL HEALTH
DEPARTMENT EXPENDITURES, BY SOURCE OF FUNDS,
FISCAL YEAR 1987

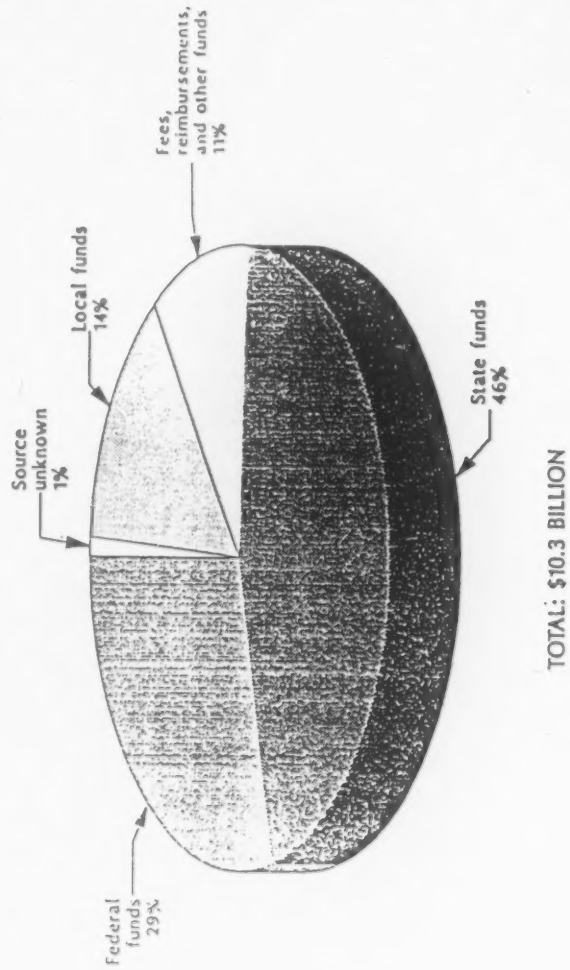
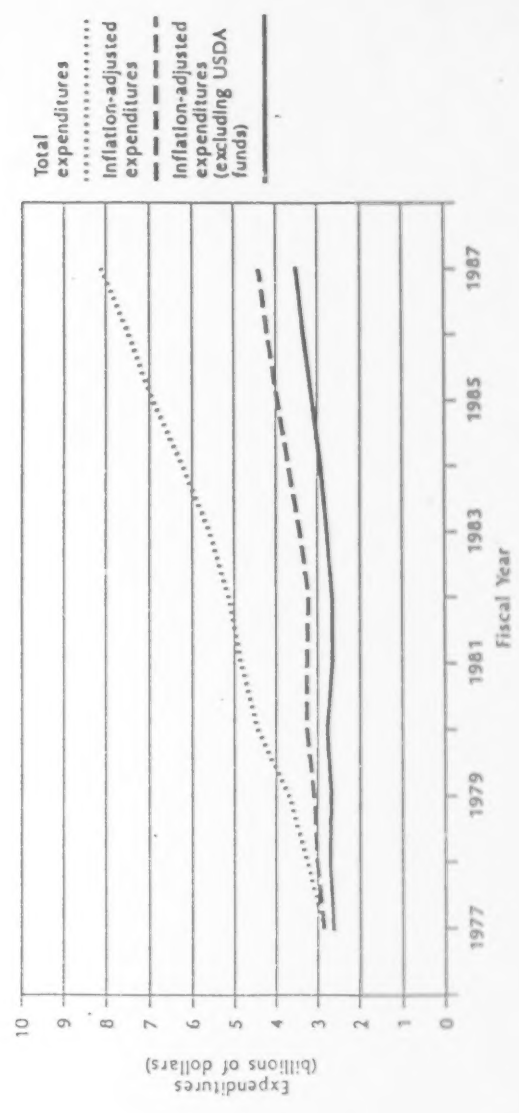


FIGURE 9.
STATE HEALTH AGENCY EXPENDITURES,
FISCAL YEARS 1977-1987

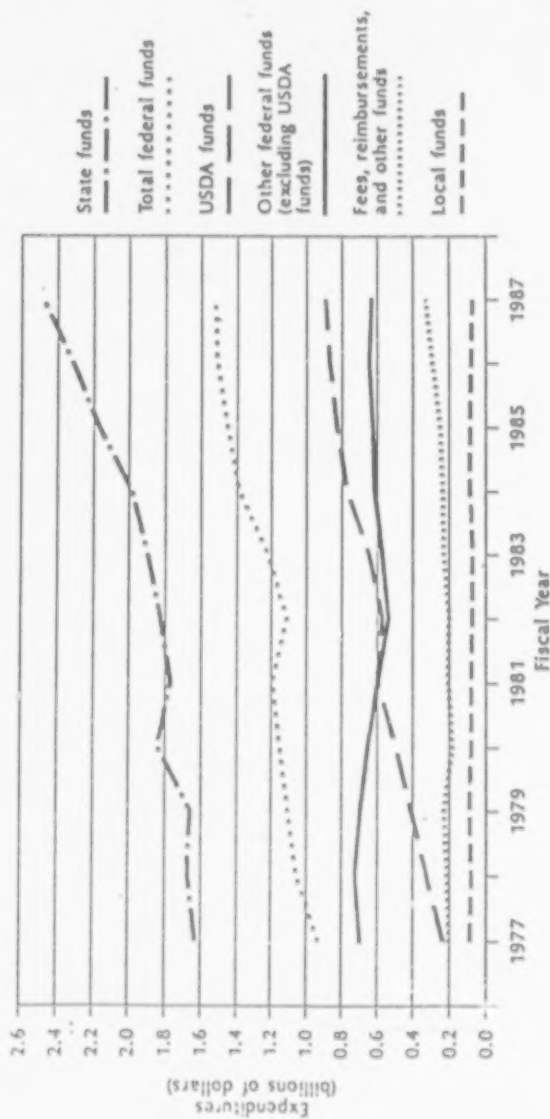


Note: Inflation-adjusted expenditures have been deflated to the equivalent of 1977 dollars. The rate of inflation is based on the "Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W)," January 1989. Other adjustments have been made to the data to account for major changes in state health agency programmatic responsibilities during the period.

Source: PUBLIC HEALTH FOUNDATION

May 1989

FIGURE 10.
STATE HEALTH AGENCY EXPENDITURES,
BY SOURCE OF FUNDS, FISCAL YEARS 1977-1987



Note: Expenditures have been deflated to the equivalent of 1977 dollars. The rate of inflation is based on the "Consumer Price Index for Urban Wage Earners and Clerical Workers (CPI-W)," January 1988. Other adjustments have been made to the data to account for major changes in state health agency programmatic responsibilities during the period.

Senator HARKIN. Dr. Fox, thank you very much. I know you need to catch an airplane. Thank you very much for being here. Your recommendations will be given serious consideration. In fact, my staff tells me we are already working with ASTHO on these, and we will be working with you.

Senator COCHRAN. Mr. Chairman, could I just say one word?

Senator HARKIN. Yes.

Senator COCHRAN. I know Dr. Fox has to leave, and I do, too. I hate to run out on you here, but he grew up medically over in Mississippi, and that is probably why he is so smart. [Laughter.] He once worked at our State Health Department. He is over there heading up the Alabama office now, but he is really one of the bright stars in public health in America today. So I am glad to hear what you said about the fact that we are working with the suggestions that they have made. I had just indicated to my staff to please get a copy of his statement. We want to be sure we can incorporate as many suggestions as possible that he has made to us because I really agree with him.

I can remember one thing he said to me on a visit to my office, and that is that WIC is the Cadillac of all these programs. I won't try to quote the other things he said about the WIC program. But we were working very hard to increase the WIC funding that year. But we also need to try to help spread the money around through some of the other initiatives—I think that was the point—and maybe provide some more flexibility at the local level. And I hope we can do that in this bill so that we don't try to tell every State health officer exactly how they have got to spend every dime. They can really make a lot of these decisions better than we can in Washington.

Thanks very much.

Senator HARKIN. Thank you, Dr. Fox.

Dr. Fox. Senator, good to see you.

Senator HARKIN. Dr. Fox, thank you very much again for being here. If you have to leave, feel free.

Dr. Fox. I can probably stay until 12:00. My plane is at 12:45.

Senator HARKIN. I see. OK.

Dr. Fox. Thank you.

Senator HARKIN. Dr. Keck, president-elect of the American Public Health Association, and director of the Department of Health for Akron, OH, since 1976. I also understand you were in the Peace Corps. Very good. Welcome, Dr. Keck. Please proceed.

Dr. KECK. Thank you, Senator Harkin. As you have already mentioned, I am here today representing the American Public Health Association, but I am also here as a representative of the United States Conference of Local Health Officers, which is a group that represents the Nation's city and county health departments, which are over 2,000. Both groups appreciate the presence of the bill and the opportunity to testify today in support of the Health Objectives 2000 Act.

As you have been hearing today, we know that the discipline of public health has a proud tradition of accomplishment. There is not much question about that. Most communicable diseases have been brought under some control. Infant mortality has been dramatically reduced, and gradually dropping death rates from chron-

ic disease indicate that those problems as well are amenable to some control.

The differences between the illness burden of the healthiest portions of our population and those groups that carry the greatest risk for disease indicate the tremendous potential that exists in this country for overall improvement in our health status. This potential is somewhat wistful, however, as we watch other industrialized nations outdistance us somewhat dramatically in their ability to achieve low infant mortality rates and greater longevity. Unfortunately, we continue to see the gap widen between our social classes in this country in the prevention of disease.

The public health tools and strategies are at hand to produce significant reductions in disease and mortality in Americans. These disease prevention and health promotion activities will not be adequately employed, however, without the kind of clear national goals that we are trying to set now, but just as importantly, the provision of the resources that we need to carry them out.

Both APHA and the U.S. Conference applaud the goals of the Health Objectives 2000 Act. Investment, we think, in those efforts now can improve our population's health and, as others have noted, substantially reduce expenditures that would otherwise have to be made in the future.

We strongly endorse the concepts that are embodied in the legislation of providing capacity and resources to States and localities to assist them in achieving these objectives in a way that would create and develop a real partnership—a real solid partnership, we would hope—of Federal, State, and local health agencies, including also voluntary health organizations, and other health groups would join us to develop initiatives for preventing disease.

The step-by-step approach outlined in the bill of assessing the health status, establishing State objectives and goals, creating a detailed plan to achieve them, and finally providing a report on the activities should improve the Nation's health and certainly should improve the accountability of all of us in our efforts to meet them.

I can assure you that the public health community is frustrated, as you have heard, with our awareness of the potential that exists to do things, but our inability to carry through sufficiently because of the lack of resources. We want to tackle these issues, and we can do a better job if the resources come to us.

While both of the organizations I am representing today do support the thrust and major provisions of the bill, we join ASTHO in asking that some revisions of the bill be considered. Certainly, we agree that it would make sense to put together a State Health Objective Advisory Committee in each State whose membership and responsibilities would be specified in the act, hopefully with local officials and voluntary health agencies being represented, where appropriate, in different States.

We also agree that we need a national data system. If we are going to ensure that the objectives of the act are met, we agree that the Secretary of the Department of Health and Human Services should work with the Centers for Disease Control and the national advisory committee to establish a uniform data set for all of the objectives that are listed. And we would hope that those data sets could be in place within 2 years of the enactment of the bill,

and that we could begin the process of reporting on conformance with the national objective data sets that are established within the next 2 years.

I think it is also important in this to emphasize the attention that should be paid to currently existing public health programs outside of the preventive health and health services block grant. We should not let passage of this act affect the continuation and, where appropriate, the growth of categorically funded programs which are also making significant contributions to the preventive services that are needed in this country. Their maintenance is essential if the goals of the act are to be realized.

We also agree that it is important in achieving these goals that when there is no longer a preventive health and health services block grant appropriation, that each State should receive at a minimum the amount equal to the amount allocated in the final year of the block grant. We certainly urge that the act be funded at the amount authorized. It is, after all, little more than a dollar per capita. We already spend much more than \$2,000 per person per year in the United States on health care. This proposal would add about one-twentieth of 1 percent to total health expenditures.

There are some other minor changes we would like you to consider. You already heard we agree with ASTHO that we would like to have APHA represented on the national advisory committee, and we would like to see some affirmative action language included in the bill as well. But in the interest of time, we will be glad to provide you with some details of those recommendations in writing rather than discuss them here.

In concluding, let me once again express our appreciation to Senator Harkin and Senator Pell and other sponsors of the bill for your leadership in identifying these gaps in our public health system and for your efforts to help us enhance the delivery of public health services around the country. We believe, as you do, that if as a Nation we don't make public health a priority, those of our citizens who are least able to fend for themselves will continue to suffer and die from preventable diseases or injuries at great cost to our economy and, of course, at great cost to the lives of those who are affected.

You will with this bill present the public health community with a very ambitious agenda. Certainly, APHA and the United States Conference and many others, I am sure, would be proud to accept that challenge, and we look forward to working with you to meet it. Thank you.

[The prepared statement of Dr. Keck follows:]

**PREPARED STATEMENT OF THE AMERICAN PUBLIC HEALTH ASSOCIATION
C. WILLIAM KECK ON BEHALF OF**

Mr. Chairman and distinguished members of the Committee, I am Dr. C. William Keck, Director of Health for the City of Akron, Ohio. I am here today as President-Elect of the American Public Health Association (APHA), the oldest and largest public health society in the world, with a combined national and affiliate membership of over 50,000 public health professionals and community health leaders, and as a representative of the United States Conference of Local Health Officers (USCLHO), representing the nation's city and county health departments of which there are over 2,000. Both groups appreciate the opportunity to testify today in support of S. 2056, the "Health Objectives 2000 Act."

The discipline of public health has a proud tradition of accomplishment. Most communicable diseases have been brought under control such that infections are no longer our major killers. Infant mortality has been drastically reduced even as the life span of those who survive infancy has increased. Gradually dropping death rates from chronic disease indicate that these problems are also amenable to control.

The differences between the illness burden of the healthiest portions of our population and those groups that carry the greatest risks for disease indicate the tremendous potential that exists in this country for overall improvement in our health status. This potential is increasingly wistful, however, as we watch other industrialized nations outdistance us dramatically in their ability to achieve low infant mortality rates and greater longevity.

The public health tools and strategies are at hand to produce significant reductions in disease and mortality in Americans. These disease prevention

and health promotion activities will not be adequately employed, however, without clear national goals and provision of the resources needed to carry them out.

The APHA and the USCLHO applaud the goals of the Health Objectives 2000 Act, which calls for a renewed national effort in the areas of health promotion and disease prevention. Investment in these efforts now can improve our population's health and substantially reduce expenditures that would otherwise have to be made in the future.

These two organizations strongly endorse the concepts embodied in this legislation of providing capacity and resources to States and localities to assist them in achieving the Year 2000 National Health Objectives, creating and developing a partnership of federal, state, and local health agencies, voluntary health organizations, and other health groups to develop initiatives for preventing disease.

The step by step approach outlined in the bill of first accessing the health status of the population of the United States, then establishing state objectives or goals, followed by creating a detailed plan to achieve those goals, and finally providing a comprehensive report on the activities undertaken should improve the nation's health and the accountability of health care providers and administrators. The public health community is ready and eager to tackle these issues, if given the resources.

While the APHA and the USCLHO wholeheartedly supports the thrust and major provisions of the bill, we ask that you consider amending it to address the following specific concerns:

Local Agency Participation

Achieving the laudable goals of this legislation will require the active participation of health professionals at all levels of government - federal, state, and local. To ensure optimal cooperation, we suggest the establishment of a State Health Objective Advisory Committee in each state, whose membership and responsibilities would be specified in the Act.

National Data System

In order to ensure that the objectives of the Act are being met, we urge that you have the Secretary of the Department of Health and Human Services direct the Centers for Disease Control to establish national uniform data sets within two years after enactment of the bill; and that the States commence reporting in conformance to the national data sets two years later. A good data collection system not only provides public health professionals with the information they need to assess their programs (and thus the health status of the public they serve), it also enables Congress and the Department of Health and Human Services to evaluate the effectiveness of various preventive health measures.

Existing Grant Programs

The APHA and the USCLHO support your view that this legislation is not meant to replace any existing programs except for the Preventive Health and Health Services Block Grant. Passage of this Act must not affect the

continuation and (where appropriate) growth of categorically funded programs such as childhood immunization, the sexually transmitted disease prevention and control program, the injury control program, Title X family planning, and others whose maintenance is essential if the goals of the Act are to be realized.

Funding

The goals and objectives of this bill are significantly more ambitious than those of the Preventive Health and Health Services Block Grant. If Congress is committed to achieving these goals, it is important that when there is no longer a Preventive Health and Health Services Block Grant appropriation, each State receive at a minimum, an amount equal to the amount allocated in the final year of the Block Grant. The APHA and the USCLHO urge that the Act be funded at the amount authorized.

There are other minor changes that we would like you to consider, e.g. adding APHA to the National Advisory Committee and including affirmative action language. In the interest of time, however, I will provide details concerning these changes to the Committee in writing.

In conclusion, let me once again express our appreciation to the bill's sponsors for their leadership in identifying gaps in our public health system and their efforts to enhance the delivery of public health services nationwide. If we as a nation do not make public health a priority, those of our citizens who are least able to fend for themselves will continue to suffer and die from preventable diseases or injuries, at great cost to our economy and to the lives of those affected.

You have presented the public health community with an ambitious agenda. The APHA and the USCLHO are proud to accept the challenge, and look forward to working with you to meet it.

Senator HARKIN. Thank you very much. My compliments also to the American Public Health Association, which I understand is the oldest public health association in the world.

Dr. KECK. Yes.

Senator HARKIN. It has been around a long time, and we are all very familiar with the fine work that you do. Both you and Dr. Fox address this point of what this bill is intended to do in terms of replacing the block grant. It is my intention—and I am sure that I speak for those that are on the bill—that the bill is intended only to act as a replacement for the expiring preventive health and health services block grant, which expires in 1992, I think 1992. This is going to be folded in next year, and then it will replace that. But in no way, I repeat, is it intended in any way to fold in the categorical programs that we now have existing, which have proven their worth. That is not our intention at all. I just want to make that clear because both of you touched on that point.

Also, I see your suggestions track very closely with ASTHO's.

Senator HARKIN. Next is Ms. Muncy. Dr. Wasserman, representing the National Association of County Health Officials, is ill today, and the testimony is presented by Suzanne Muncy, who is Deputy Director of Health, Montgomery County, Maryland. Welcome, and please proceed.

Ms. MUNCY. Thank you, Senator Harkin and Senator Pell. Thank you very much. I heard your comment earlier that the testimony will be submitted for the record, so I will diverge a little bit from that in the interest of time and perhaps to add a few other comments as I have been listening to the testimony.

I am Suzanne Muncy. I am the deputy director of the Montgomery County Department of Health. It is a health department representing over 500 employees and a budget of approximately \$27 million. We are a local health department. We are prevention-oriented. We provide well services, primarily prenatal, maternity services, nutrition services, the WIC services, well-child. We do not provide sick services. So we are very much interested in the prevention aspects of this bill from that perspective.

I would also mirror and support the previous testimony, and I will try not to repeat much of what has already been said, other than to indicate that we very much support the bill and the way in which it is intended.

Taking advantage of the experience and the knowledge that has been gained during the past 12 years through the development and implementation of the 1990 objectives, the Health Objectives Act will greatly provide the targeted needed funding that will assist the State and local governments in implementing a set of national health objectives for the year 2000. These objectives have been established through the collective efforts of more than 300 public and private health care-oriented agencies during the past 2 years.

In regard to our future, in 1988 the Institute of Medicine's report on "The Future of Public Health" declared the public health system to be "in disarray." No single word has created more challenge and injected more energy into those of us within the public health field than the term "disarray" did 18 months ago. The expectations for accomplishing significant improvements has never

been higher than at this time, and particularly with this legislation.

In September, we will learn of the specific outcomes to be defined by the objectives for the next 10 years. There must be funding support to assure the satisfactory implementation at the State and local level. Senate Bill 2056 will provide this vital and necessary financial assistance.

Let me shift for a moment and tell you a little bit about the needs that this act might help at the local level. I live and work in Montgomery County. Some of you all may also. We are just to the northwest of the District of Columbia. While you may recognize us generally as one of the wealthier communities in this country, there are things that you probably do not know about the county:

Greater than one-fourth of our population consists of minorities and nonEnglish-speaking persons. We have a sizable undocumented immigrant population. We have the largest Hispanic population in the State of Maryland and the second largest in the metropolitan area.

Thirty million dollars of next year's county budget will be targeted for substance abuse activities. The county has one of the strongest no-smoking laws in the country. We have had a measles problem because people are not being vaccinated for measles.

Nearly 1.5 percent of my department's budget will be dealing with AIDS and HIV infection next year.

We have more than 2,000 individuals in the county, many of them children, who are homeless.

We have over \$2 million in a special maternity program that is administered by a nurse that includes high-risk pregnancies and high-risk infants, substance-abusing pregnant women, home visiting—which we instituted again just recently after a 10-year absence, and due to a lack of funds. We provide nutrition and a special outreach program for minorities. I would volunteer to say that many people in the county do not have a regular physician or a dentist. Health prevention is very different than a sick visit or someone waiting until they are sick to see a physician.

Our county has grown nearly 25 percent during the 1980's, and its demographic changes are so markedly different that few people recognize the reality of that change and what it means. The reason I mention this is that counties all over America are undergoing similar changes. We are not particularly unique, and the health implications of this turbulence are substantial.

I am also representing today the National Association of County Health Officials, which represents more than 2,900 health officers from small to large communities across this country. We are the "voice" of the local health officials. You have our support for this legislation and for implementing and seeing that it is implemented at the State and local level. If we are to be successful in meeting the challenges that lay ahead, then we must create a solid foundation and a lasting partnership, not only among the three levels of Government—Federal, State, and local—but also the private sector.

A note of caution that was mentioned earlier, too, is to please consider that this act is not a replacement for any existing categorical health program or to reduce the appropriation of the preven-

tion block grant. That would have a disastrous effect on our public health system.

On another note, a byproduct of this bill is the improved and perhaps even a uniform data reporting system. We are sadly lacking in local data. Your comments earlier, Senator Harkin, on disabilities requires incidence reporting data. This would greatly move us along toward trying to find that data. At the moment, we are getting ready to implement an injury prevention program, and we are starting off with a bike helmet and bike safety program. We do not have any idea how many children are seriously injured every year from bike accidents or what a helmet would do to reduce the risk of serious injury. We only know the number of children who are killed from a bike accident. So having this data alone would move us forward tremendously in developing our programs.

Thanks go out to the Association of State and Territorial Health Officials, which is to be commended for their creativity and their energy in putting forth and supporting this piece of legislation. And appreciation goes to you and to your committee in support and for your leadership in moving this legislation forward.

Thank you.

[The prepared statement of Dr. Wasserman follows:]

PREPARED STATEMENT OF DR. MARTIN P. WASSERMAN

PRESIDENT, NATIONAL ASSOCIATION OF COUNTY HEALTH OFFICIALS

Dr. WASSERMAN. Senator Harkin, Senator Kennedy, Senator Hatch, members of the Senate Labor and Human Resources Committee, good morning. I am Dr. Martin P. Wasserman, director of health for Montgomery County, Maryland, and currently president of the National Association of County Health officials. My purpose in coming before you today is to offer both my personal and my organization's strong support for S. 2056, the Health Objectives 2000 Act. We believe this single piece of legislation can provide the vehicle for a new "vision of public health" for the next generation.

Taking advantage of the experience and knowledge gained during the past 12 years through the development and implementation of the 1990 Objectives, the Health Objectives 2000 Act will provide targeted funding to assist State and local governments in implementing a set of national objectives for the Year 2000. These Objectives have been established through the collective effort of more than 300 public and private health care oriented agencies during the past 2 years. A strong and innovative investment of Drs. McGinnis, Harrell, and the staff from the office of Disease Prevention and health Promotion has indeed led to a remarkable and exciting plan for our public health future.

In regard to our future, as recently as November 1988, the Institute of Medicine's report "The Future of Public Health" declared the public health system to be "in disarray." I am here to tell you this morning that no single word has created more of a challenge and injected more vigor into those of us within the field of public health than the term "disarray" did 18 months ago. While one can reasonably question the overall status of the entire American health care delivery system—and many national institutions are currently so doing—the expectations for accomplishing marked improvements in our public health status have never been higher.

Although we will need to wait until September to learn of the specific outcomes defined by the Objectives, the need for funding support to "assure" their satisfactory implementation at the State and local level must be recognized and met. S. 2056 will provide this vital and necessary financial assistance.

Let me shift gears, for a moment, and tell you a little bit about the need for this act's of support at the local level. As you know, Montgomery County is the Maryland jurisdiction adjoining the district of Columbia to the north. We have a population of approximately 730,000. While you may recognize us as one of the wealthier jurisdictions in the country, what you probably do not know is that:

Greater than one-fourth of our population consists of minorities and non-English speaking persons.

Thirty million dollars of County Executive Kramer's fiscal year 1991 budget will be directed toward dealing with the problem of substance abuse and that does not include efforts made by the schools.

Nearly \$1.5 million will be spent in my department's budget dealing with Acquired Immune Deficiency syndrome and HIV infection.

Approximately 2,000 individuals (many of them school-age children) are without permanent shelter and remain part of the tragedy of America's homeless population.

Our county has grown by nearly 25 percent during the 1980's and its demographics have changed so markedly that, in all honesty, our residents do not really know who they are and what they have become. The reason I mention this in the context of my support for the Health Objectives 2000 Act is that counties across America are undergoing similar changes, and the health implications of this turbulence are substantial.

The National Association of County Health Officials represents more than 2,900 of my fellow health officers from communities as small as Caldwell County, Missouri, to counties as large as Los Angeles, California. We are the "Voice" of county health officials and our board has discussed and supported this bill. Furthermore we have presented it to our general membership for their review and consideration. If we, as a nation, are to be successful in meeting the challenges that lay ahead in the next century, and we intend to pass on a healthier America to the next generation, then we must support this act and create a solid foundation for a lasting partnership among the three levels of government—Federal, State, and local.

Let me conclude by describing for you my synthesis of the vital parts of this act and how it will serve the critical function of providing the necessary leadership to underscore this inter-governmental partnership and to promote the well-being of America's citizens:

A State Advisory Group will be created to assess specific health needs and develop a State plan of action.

Representatives from both State and local health department will bring their unique perspective on the health issues to this forum to assure that a broad, diverse and complete plan is considered.

The core functions of Assessment, Policy Development, and Assurance, identified in the IOM report, will be a critical concern of this committee.

The Health Objectives 2000 Act will provide the necessary funding to stimulate this process and furthermore will require a response from each State.

Finally, a note of caution—

Please do not consider this act as a replacement for any existing categorical health program or reduce the appropriation for the Prevention Block Grant—that would have disastrous effects on our public health system.

And a note of optimism—

A necessary byproduct of this process is likely to be an improved, and perhaps even a uniform, data reporting system. That alone would move us significantly forward.

Thanks go out to the Association of State and Territorial Health Officials, our sister organization, which is to be commended for the creativity, energy and effort put into this piece of legislation and thanks go out to you in the Senate who have demonstrated bipartisan support for this measure to improve the health status for all of us.

Senator HARKIN. Thank you very much for being here today.

Next we will turn to Dr. Jane Delgado, National Coalition of Hispanic Health and Human Services Organizations. Welcome and please proceed.

Ms. DELGADO. Thank you for having us here. Unfortunately, as usual, when we have to testify, one of the things that we have to do is be very supportive of bills, but at the same time understand that very often the needs of those people who are under-served and who suffer disparities in health are not sufficiently addressed in what is in front of us. We can start with Health Objectives 2000, and while we have been working with Mike McGinnis and Jim Harrell from the Office of Health Promotion and Disease Prevention from the very beginning, of those 300 organizations which you mentioned,

very few actually represent the voices of blacks, Hispanics, Native Americans, and Asian Pacific peoples.

Our concerns are three with those objectives, as we were going around the country promulgating them. One is that there aren't sufficient component objectives for each of those communities. So that if you look at the area of chemical dependency, violence, and suicide, there is nothing that relates to these populations. The second is that special population targets have been developed which are less than for the overall population. And while we are glad that we are trying to close the gap, our goals should be to get rid of the gap in health disparities completely. The third thing is that all of the under-served communities which I have mentioned have worked together and are composing a letter because we are concerned that a priority area on minority health has not been brought forward. This is important for two reasons. First of all, when we look at disparity and where we need the most change and improvement in the health of our Nation, that is an area that needs a lot of improvement.

So those are, to begin with, some of our concerns about the Health Objectives 2000, and I think that we need more support from people in order to have those objectives be responsive. Otherwise, when the year 2000 comes, we will be measuring the wrong thing. We will have data on issues which are out of date and do not represent what this country will look like in the year 2000. I think we have to look to the future, at our population trends, and really see what America will be like.

The second thing that we wanted to talk about is that as the bill stands, as a person who was very much involved in implementation of the social services block grant and the community services block grant, I am very glad it is a block grant program. I think that giving money to States is a very important way to go. I think as we do that, though, we have to be very careful as to how we proceed in that role. If you look at both of those block grants and how they progressed, one was initially really a State program, which was a Title XX program, and we gave a block grant out and it worked well. But the other program, the community services block grant, was originally a Federal local program. The problem we had was developing those relationships between States and local community-based organizations. We have had that again most recently with AIDS and HIV infection. How do you get communities involved in health promotion in that area?

So the issue is how do you make a block grant responsive to local community. One thing that we very much appreciate and require is when community-based organizations, their involvement is mandated in bills. If they are not mandated, they will not be part of the solution. We find that States often appreciate this because it encourages them to forge new relationships with organizations they have not worked with in the past.

The third thing we are concerned about is the repeated nature of good data. Good data is crucial, but as you may know, 1989 was the first year that nationally States collected data on birth and death of Hispanics. Good data is not available, and given what we know now, it will not be available in the future either. Two years is not

sufficient time, and data has to include breakout by race and ethnicity. And legislation has to say this; otherwise, it will not occur.

Those are some of the concerns that we have, and I am glad to be here, and I am glad that we are taking this first step in the right direction. However, while other people here are the voices of people who serve in the area of health, our organization is actually the voice of the under-served and what they need. And I think you have to look at who are the people who you want to serve now and in the year 2000 and whose health do you want to promote.

Thank you.

[The prepared statement of Ms. Delgado follows:]

PREPARED STATEMENT OF JANE L. DELGADO

THANK YOU. MY NAME IS JANE DELGADO, AND I AM PRESIDENT AND CEO OF THE NATIONAL COALITION OF HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATIONS, OTHERWISE KNOWN AS COSSMHO. COSSMHO IS THE ONLY NATIONAL HISPANIC HEALTH AND HUMAN SERVICES ORGANIZATION IN THE UNITED STATES, AND AS SUCH REPRESENTS THE HEALTH INTERESTS OF THE NATION'S HISPANIC POPULATION. HISPANICS RESIDE IN EVERY STATE IN THE UNION, WITH MAJOR CONCENTRATIONS IN CALIFORNIA, TEXAS, NEW YORK, FLORIDA, ARIZONA, NEW MEXICO, NEW JERSEY, ILLINOIS, AND COLORADO. ALL TOGALED, THE 22 MILLION HISPANIC AMERICANS ACCOUNT FOR APPROXIMATELY 9% OF THE U.S. POPULATION-- ABOUT 19 MILLION MAINLAND RESIDENTS AND AN ADDITIONAL 3 MILLION IN PUERTO RICO.

ACHIEVING THE YEAR 2000 OBJECTIVES ARE CRITICAL

BY THE YEAR 2000 HISPANICS WILL REPRESENT AT LEAST 12% OF THE POPULATION. THUS, THE YEAR 2000 OBJECTIVES ARE CRITICAL NOT JUST TO THE WELL-BEING OF THE HISPANIC COMMUNITY, BUT TO THE FUTURE WELL-BEING OF THE UNITED STATES. NEVERTHELESS, IT

IS IMPORTANT TO REALIZE THAT AS CURRENTLY PROMULGATED THE OBJECTIVES FAIL TO ADEQUATELY ADDRESS HISPANIC ISSUES. THEY NEED RESTRUCTURING IN THREE MAJOR WAYS:

1. *COMPONENT OBJECTIVES ADDRESSING HISPANICS MUST BE INCLUDED IN ALL OF THE PRIORITY AREAS.*

THE ABSENCE OF OBJECTIVES IN SEVEN PRIORITY AREAS PROVIDES A MISLEADING PICTURE OF THE CURRENT STATUS OF HISPANIC HEALTH. IN ADDITION TO INCLUDING OBJECTIVES WHICH ADDRESS PRIMARILY CARDIOVASCULAR RISK FACTORS, IT IS EQUALLY, IF NOT MORE, IMPORTANT TO LOOK AT AREAS IMPACTING POTENTIAL YEARS OF LIFE LOST. THESE WOULD INCLUDE CHEMICAL DEPENDENCY, VIOLENCE AND HOMICIDE. COMPONENT OBJECTIVES ADDRESSING HISPANICS MUST BE INCLUDED IN ALL OF THE PRIORITY AREAS.

2. *THE SPECIAL POPULATION TARGETS SHOULD BE THE SAME AS THE OVERALL POPULATION TARGETS.*

WHILE WE RECOGNIZE THAT OFTEN THE BASELINE FOR HISPANICS IS EITHER HIGHER OR LOWER THAN THE REST OF THE POPULATION AND THAT THE RATE OF PROPOSED CHANGE IS OFTEN GREATER, WE WOULD RECOMMEND THAT THE

TARGETS BE THE SAME AS THE OVERALL POPULATION. IT SIMPLY DOES NOT MAKE SENSE TO GO INTO THIS WHOLE PROCESS ACCEPTING DIFFERENT TARGETS FOR DIFFERENT GROUPS. OUR AIM SHOULD BE TO "ELIMINATE THE GAP" RATHER THAN TO SETTLE FOR "CLOSING THE GAP."

3. *A SEPARATE PRIORITY AREA ON MINORITY HEALTH SHOULD BE CREATED.*

WHILE IT IS IMPORTANT TO INTEGRATE THE COMPONENT OBJECTIVES WITHIN THE OVERALL PRIORITY AREAS, IT IS EQUALLY CRITICAL TO HIGHLIGHT THE IMPORTANCE OF THE SPECIAL POPULATION TARGETS. I AM CONVINCED THAT THIS CAN ONLY BE ACHIEVED BY CREATING A SEPARATE PRIORITY AREA FOR MINORITY HEALTH. THIS WOULD PROVIDE A CLEAR STATEMENT ON THE IMPORTANCE OF THE SPECIAL POPULATION TARGETS. MOST IMPORTANT, IT ALLOWS FOR MORE CAREFUL MONITORING OF PROGRESS TOWARDS ACHIEVING THE OBJECTIVES.

WHILE MANY OF THE OBJECTIVES WOULD BE CROSS-REFERENCED THERE WOULD BE SOME CROSS-CUTTING THEMES SUCH AS: "INCREASING THE AWARENESS OF EACH OF THE SPECIAL POPULATION GROUPS ABOUT RISK FACTORS AND REDUCTION MEASURES CITED IN THE 'RISK REDUCTION'

SECTIONS"; AND, UNDER "SERVICES AND PROTECTION," INCREASING THE AVAILABILITY OF CULTURALLY AND LINGUISTICALLY RELEVANT SERVICES.

ALL THIS MUST BE DONE IN RECOGNITION OF THE FACT THAT ONE OF THE MOST IMPORTANT CHARACTERISTICS OF THE HISPANIC COMMUNITY IS A RAPID RATE OF GROWTH. THE MAJOR CONTRIBUTION TO THIS DRAMATIC POPULATION GROWTH IS OFTEN MISTAKEN TO BE IMMIGRATION. IN FACT, IT IS THE HIGH FERTILITY RATE OF HISPANIC WOMEN-- 102.2 FOR MEXICAN-AMERICAN WOMEN, 67.7 FOR PUERTO RICANS, AND 108.8 FOR "OTHER" HISPANIC WOMEN, PRIMARILY OF CENTRAL AND SOUTH AMERICAN DECENT, COMPARED TO 65.0 FOR NON-HISPANIC FEMALES. FURTHERMORE, BECAUSE OF THIS RAPID GROWTH IT IS CONSERVATIVELY ESTIMATED THAT HISPANICS WILL COMPRISE 1 IN 5 WORKING AGE PERSONS BY THE TURN OF THE CENTURY.

SENATOR HARKIN QUITE RIGHTLY STATED THAT A HEALTHY WORKFORCE IS ESSENTIAL IN ORDER TO MAINTAIN OUR NATION'S HIGH LEVELS OF PRODUCTIVITY AND COMPETITIVE STANCE IN THE WORLD MARKET. AS SUCH IT IS CRITICAL THAT WE ADDRESS THE HEALTH NEEDS OF ALL AMERICANS, INCLUDING HISPANICS, AS WE STRIVE TO

ACHIEVE THE HEALTH OBJECTIVES FOR THE YEAR 2000.

UNFORTUNATELY, THE HEALTH OBJECTIVES 2000 ACT WILL NOT BE USEFUL IN PROMOTING AN EQUITABLE ASSESSMENT OF THE HEALTH NEEDS OF ALL AMERICANS, NOTABLY HISPANICS, AND AS SUCH DOES NOT SERVE ITS STATED GOALS. IN FACT, IT WILL ASSIST IN WIDENING THE ALREADY WIDE GAP BETWEEN HISPANIC HEALTH AND THE HEALTH OF THE GENERAL POPULATION.

HISPANIC HEALTH STATUS

DESPITE SIGNIFICANT CONTRIBUTIONS TO THE HISTORY, ACHIEVEMENTS, AND HERITAGE OF THE UNITED STATES HISPANIC AMERICA CONTINUES TO SUFFER DISPROPORTIONATELY.

- THE POVERTY RATE AMONG HISPANIC FAMILIES IS 24.7% COMPARED TO 9.9% FOR NON-HISPANIC FAMILIES.
- HISPANICS REPRESENT 17.7 % OF ALL AIDS CASES BUT ONLY 9% OF THE POPULATION.
- HHANES DATA SHOW THAT THE PREVALENCE OF UNDIAGNOSED DIABETES IS 9.6 PERCENT FOR MEXICAN AMERICANS, 11.8

PERCENT FOR PUERTO RICANS, AND 9.9 PERCENT FOR CUBAN AMERICANS AS COMPARED TO 6.1 PERCENT FOR NON-HISPANIC WHITES AND 9.3 PERCENT FOR NON-HISPANIC BLACKS IN THE GROUP AGES 45 TO 74 YEARS.

- WHILE COCAINE USE AMONG THE TOTAL POPULATION HAS BEEN DECLINING, THERE HAS BEEN A SIGNIFICANT INCREASE AMONG HISPANICS. THE PERCENTAGE OF NON-HISPANIC WHITES WHO REPORTED USING COCAINE AT SOME POINT IN THEIR LIVES FELL FROM 12.4 PERCENT IN 1985 TO 10.8 PERCENT IN 1988. FOR HISPANICS, THE FIGURE ROSE FROM 7.3% IN 1985 TO 11.0% IN 1988.
- ALMOST 1 IN 3 HISPANICS DO NOT HAVE A REGULAR SOURCE OF HEALTH CARE, AND 1 IN 4 DO NOT HAVE MEDICAL INSURANCE.

THE REASONS FOR THESE OVER-REPRESENTATIONS IN THE INCIDENCE OF DEATH AND DISEASE ARE VARIED AND SOMETIMES COMPLEX. EDUCATION, INCOME, AND LEVEL OF ACCULTURATION ALL PLAY A SIGNIFICANT ROLE. THE NEED FOR DISEASE PREVENTION AND HEALTH PROMOTION INTERVENTIONS IS CLEAR, AND IF THEY ARE TO BE SUCCESSFUL THEY MUST BE

COMMUNITY-BASED.

COMMUNITY-BASED INTERVENTIONS

AS IT STANDS, THE HEALTH OBJECTIVES 2000 ACT IS LACKING IN THAT IT DOES NOT SPECIFICALLY PROVIDE FOR THE PARTICIPATION OF COMMUNITY-BASED ORGANIZATIONS (NON-PROFIT, NON-GOVERNMENTAL ENTITIES)-- LONG THE ACTIVE PROVIDERS OF SERVICES TO HISPANIC COMMUNITIES ACROSS THE COUNTRY. YET IT IS PRECISELY THE PARTICIPATION OF THE COMMUNITY IN ASSESSING THEIR NEEDS AND PLANNING RESPONSES THAT IS CRITICAL IN THE DEVELOPMENT OF EFFECTIVE PROGRAMS FOR HISPANIC COMMUNITIES.

PERHAPS THE CLASSIC EXAMPLE OF THIS IS CASE OF THE "AMERICA RESPONDS TO AIDS" EDUCATION CAMPAIGN. SEEKING TO INFORM THE HISPANIC COMMUNITY, A MESSAGE WAS DEVELOPED AND BROADCAST NATIONALLY THAT EMPHASIZED THE HIGH INCIDENCE OF AIDS. WHEN AIRED IN THE SOUTHWEST UNITED STATES, THE RESULT WAS A PANIC AMONG COMMUNITIES FOR WHICH THE INCIDENCE OF AIDS WAS ACTUALLY LOW AND THE MOST IMPORTANT THING WOULD HAVE BEEN TO EMPHASIZE PREVENTION. BEING ON THE FRONT-LINE IN THE TARGET AREAS CBOs KNEW THIS, AND HAD THEY BEEN CONSULTED THE

DOLLARS USED TO CREATE THE SPANISH-VERSION OF THE AD AND TO AIR IT WOULD NOT HAVE BEEN WASTED.

WHILE THE IMPORTANCE OF INVOLVING CBOs IN ASSESSMENT AND PLANNING IS WELL-ESTABLISHED, STATE HEALTH AGENCIES HAVE HISTORICALLY IGNORED RACIAL/ETHNIC COMMUNITIES IN THE PLANNING OF HEALTH AND HUMAN SERVICES PROGRAMS. FOR A VARIETY OF REASONS AS WELL AS JUST PLAIN INERTIA THE GAP IN CONTACT BETWEEN STATE HEALTH AGENCIES AND THE COMMUNITY-BASED ORGANIZATIONS IN THE TRENCHES IS WIDE. OFTEN STATE HEALTH AGENCIES ARE EAGER TO FUND MORE TRADITIONAL ORGANIZATIONS AS THEY VIEW CBOs SERVING HISPANIC COMMUNITIES AS ADVERSARIES SINCE THESE AGENCIES ARE ALWAYS POINTING OUT THE NEEDS OF UNDERSERVED COMMUNITIES. IN FACT, THE OPPOSITE IS TRUE.

PERHAPS THE BEST RECENT EXAMPLE OF THIS WAS THE INCORPORATION OF MINORITY COMMUNITY-BASED ORGANIZATIONS IN AIDS EDUCATION PROGRAMS. ALTHOUGH STATES WERE REQUIRED BY CONGRESS TO PROVIDE A CERTAIN PORTION OF FUNDS EARMARKED FOR AIDS EDUCATION/PREVENTION TO CBOs, IT TOOK FROM 1 TO 2 YEARS FOR STATE HEALTH AGENCIES TO IDENTIFY THOSE GROUPS. AS A RESULT, A CRITICAL TIME-FRAME FOR PROVIDING AIDS PREVENTION SERVICES TO UNDERSERVED COMMUNITIES WAS LOST. THIS DEFICIENCY IN

THE OPERATION OF STATE HEALTH AGENCIES WILL CERTAINLY BE COSTING LIVES TO AIDS IN THE NEAR FUTURE. MOREOVER, IT IS CLEAR THAT IF STATES ARE PROVIDED FUNDS IN FURTHERANCE OF THE YEAR 2000 OBJECTIVES WITHOUT A CLEAR MANDATE THAT CBOs MUST BE INCORPORATED IN THE ASSESSMENT AND PLANNING PROCESS, THEY WILL MOST OFTEN BE EXCLUDED, EITHER ACTIVELY OR PASSIVELY.

IT SHOULD BE NOTED HERE THAT THE USE OF THE STATE BLOCK GRANT PROCESS TO FURTHER THE DEVELOPMENT OF STATE-SPECIFIC HEALTH STRATEGIES IS IMPORTANT IN THIS REGARD BECAUSE IT HELPS MOVE US AWAY FROM THE FALLACY THAT WHAT WILL WORK IN ONE COMMUNITY WILL AUTOMATICALLY WORK IN ANOTHER-- IT RECOGNIZES THE NEED FOR STATES TO RESPOND TO THE UNIQUE HEALTH PROBLEMS FACING ITS CITIZENS. WE MUST TAKE THIS ONE STEP FURTHER AND RECOGNIZE THE CRITICAL IMPORTANCE OF ENSURING THAT COMMUNITIES PARTICIPATE IN ASSESSING THEIR HEALTH AND PROGRAMMING SOLUTIONS TO PROBLEMS.

HISTORY HAS MADE HISPANICS RIGHTFULLY CAUTIOUS ABOUT PROGRAMS DEVELOPED "FOR OUR BENEFIT." COSSMHO IS EFFECTIVE IN SERVING HISPANIC COMMUNITIES BECAUSE WE RECOGNIZE THAT FOR INTERVENTIONS TO BE SUCCESSFUL THE HAND OF THE COMMUNITY MUST BE PRESENT THROUGHOUT THE

ENTIRE PROCESS, I.E., FROM SHAPING THE INITIATIVES TO THE EVALUATION OF THE EFFECTIVENESS OF SPECIFIC INTERVENTIONS. COMMUNITIES MUST AT LEAST BE CO-PARTNERS IN THE CONCEPT, DESIGN, AND IMPLEMENTATION OF PROGRAMS WHICH ARE TARGETED TO THEM. THAT MEANS THEY MUST ALSO BE PROVIDED WITH THE NECESSARY FINANCIAL RESOURCES TO BE CO-PARTNERS. THAT THIS IS TRUE IS PERHAPS BEST DEMONSTRATED BY THE FACT THAT DESPITE LIMITED RESOURCES, COSSMHO IS EFFECTIVE IN DELIVERING PREVENTION MESSAGES, HEALTH SERVICES, AND OTHER HUMAN SERVICES TO MANY HISPANICS BECAUSE OF OUR STRONG TIES TO THE COMMUNITIES WE SERVE. STATE HEALTH AGENCIES CAN BE EFFECTIVE AS WELL, BUT THEY MUST BE MADE TO USE THE EXPERTISE OF THE COMMUNITIES THEY ARE ATTEMPTING TO SERVE.

FINAL POINTS

- KNOWING THAT IT IS IMPERATIVE FOR CBO INVOLVEMENT FOR EFFECTIVE INTERVENTION IS NOT ENOUGH-- IT MUST BE MANDATED. TO NOT SPECIFICALLY PROVIDE FOR THAT INVOLVEMENT CONSTITUTES ZERO EFFORT OR INTENT TO REACH THE HISPANIC COMMUNITY, AS MESSAGES AND

SERVICES "TARGETING" IT ARE DESTINED TO FAIL. IT IS CRITICAL TO SPECIFICALLY INCLUDE IN THE HEALTH OBJECTIVES 2000 ACT COMMUNITY-BASED ORGANIZATIONS AS NECESSARY TO ASSESSMENT AND PLANNING REGARDING THE HISPANIC COMMUNITY'S HEALTH AND HUMAN SERVICE NEEDS.

- THE USE OF THE STATE BLOCK GRANT PROCESS IS IMPORTANT AND SHOULD BE CONTINUED. IT CORRECTLY RECOGNIZES THE NEED TO MOVE AWAY FROM THE FALSE NOTION THAT WHAT WILL WORK OR IS NEEDED IN ONE COMMUNITY OR STATE WILL WORK OR IS NEEDED IN ANOTHER.
- THE PROCESS BY WHICH FUNDS ARE DISTRIBUTED BY STATES NEEDS TO BE MANDATED-- ESTABLISHED COMMUNITY ORGANIZATIONS OF RACIAL/ETHNIC MINORITY GROUPS NEED TO BE BROUGHT INTO THE STATE PLANNING AND REVIEW PROCESS TO ENSURE THAT MINORITY CBOs RECEIVE A FAIR PORTION OF STATE BLOCK GRANT MONIES COMMENSURATE WITH THE HEALTH CHALLENGES THEY FACE.

Senator HARKIN. Thank you very much, Dr. Delgado.

I have questions for some of you, but I would like to defer to Senator Pell. I know he has to leave right away.

Senator Pell, do you have any comments or questions?

Senator PELL. Just thank you so much, Senator Harkin, for holding this hearing and for your leadership in this whole field. I would like to express my thanks to Dr. Fox for replacing on such short notice Dr. Scott, and I look forward to perusing your joint testimony. I apologize for not having been here for as much of the time as I would have liked.

Thank you very much, Senator Harkin.

Senator HARKIN. Thank you very much, Senator Pell. I also want to publicly thank you—you have preceded me for some time on this panel—for all of your strong support for public health and public health services.

Senator PELL. Thank you very much.

Senator HARKIN. You have a long and distinguished career, and I appreciate that very much.

Dr. Delgado, I am trying to get a handle on exactly what you are saying. I think what you are saying is that there should be a separate priority for minority health.

Ms. DELGADO. Right.

Senator HARKIN. That is really the nub of what you are saying, right?

Ms. DELGADO. That is right.

Senator HARKIN. But in all of these priorities, I am told—believe me, I am very sensitive to this, and I want to make sure we work this out. But in the priority areas, I understand in all the list of priorities, minority health is listed in some of these priority areas.

Ms. DELGADO. I think that there is a problem in how it is mentioned, in two ways. First of all, that specifically in chemical dependency, violence, and homicide, there is no mention of activities with Hispanics. That one I know for certain. And those are things which are very important in potential years of life lost. If you look at the priorities, they are missing there.

The other thing is that one of the things that they are doing with Health Objectives 2000 is pulling out certain of the components—like on children, on the elderly, and things like that—and making them separate sections so people can track them better. I can understand why it would not be advisable for some people to separate the minority ones out separate because I think we may not be doing so well on those. And to have them all together documenting what our progress is, if any, may not be in the best interest of people who want to show progress.

However, I think that for the year 2000, given that 25 percent of the population is going to be black and Hispanic, and then you add Asian Americans, Pacific Americans and Native Americans, it is a substantial number. And because of that, it is important to look to the future and see what will be happening then.

Senator HARKIN. Dr. Delgado, I just want to make sure that we do track with you on this. Where are you located?

Ms. DELGADO. Right here in Washington.

Senator HARKIN. Oh, you are in Washington.

Ms. DELGADO. Yes. Also, just so you know, I worked on the Black and Minority Health Task Force report in 1985 from HHS, which really documented the disparity. And one of the things when you talk about data, the major footnote we got in most of the charts was that we had good data on blacks and Asians and Native Americans and whites, and for Hispanics we had a little footnote that said, "Hispanic data not available." But that is changing now.

Senator HARKIN. All right. Well, I would just ask you to keep in contact with staff and subcommittee staff as we work through this. It is just in the starting process.

Ms. DELGADO. OK.

Senator HARKIN. Other changes that were recommended, we are going to be working with these people. We want to work with you on it to make sure that we don't let some things fall through the cracks. You make a good point that we have to focus on these certain populations to make sure that they track what we are doing with the other populations, too.

Ms. DELGADO. Right.

Senator HARKIN. We don't want to leave some people behind.

Ms. DELGADO. Thank you.

Senator HARKIN. How best to do that in the priorities, I am not certain I have that kind of wisdom, but I will be glad to work with you to see how we implement that. Just keep in contact with our staff.

Ms. DELGADO. OK.

Senator HARKIN. Any other last things from any of you? Again, I just appreciate you all being here. I don't have any further questions, I don't believe, other than to say that we are going to be moving this bill. The information you have given us has been very helpful as we move it forward. Trying to keep people healthy rather than waiting until they get sick, by promoting health and preventing disease, we have an opportunity to save lives and improve the quality of life. I just think that we are really at an edge here. More and more people are looking toward preventative health care and health promotion, among a broad spectrum—the business community, the insurance industry, and certainly the general populace. If anything, I think the decade of the 1990's will be the decade of disease prevention and health promotion. This will be the decade of preventative medicine. I think we are going to see a big shift in this area in this country as far as that.

I think this bill, with your help and your input as we move it through, is going to do a lot to move us in that direction.

Again, thank you all for being here, and we look forward to working with you as we move ahead into the 1990's. Thank you all very much.

[Additional statements and materials submitted for the record follow:]

TESTIMONY SUBMITTED TO THE
COMMITTEE ON LABOR AND HUMAN RESOURCES
UNITED STATES SENATE - APRIL 20, 1990

PARTNERS FOR IMPROVED NUTRITION AND HEALTH (PINAH):
SELF-HELP, PARTNERSHIPS, OUTREACH AND ACCESS

MISSISSIPPI STATE DEPARTMENT OF HEALTH
THE FREEDOM FROM HUNGER FOUNDATION
MISSISSIPPI COOPERATIVE EXTENSION SERVICE

Partners for Improved Nutrition and Health is a joint effort of the Mississippi State Department of Health, the Mississippi Cooperative Extension Service and the Freedom From Hunger Foundation. The primary aim of P.I.N.A.H. is to bring about local self-help activities yielding sustained improvements in the nutrition and health of low-income residents in Leflore and Humphreys Counties in Mississippi. The second goal is to establish and disseminate models for self-help nutrition and health improvement which are suitable for replication in other counties of Mississippi and other parts of the rural South. The projects in the two counties are very different, but they have a common foundation.

LEFLORE COUNTY
PARTNERS FOR LIFE

In the Leflore County "Partners for Life" project, five trained paraprofessional educators, employed by the Cooperative Extension Service through EFNEP (Expanded Food and Nutrition Education Program) are enrolling 75 high-risk, low-income pregnant WIC mothers in a basic nutrition and health education program designed to improve their pregnancy outcomes. Each client receives five one-hour in-the-home lessons, plus three small-group lessons during her pregnancy. For the year after the birth of her baby, there is one lesson per month in her home, and one group lesson per month with other mothers.

WIC
EFNEP

The lessons cover balanced diet planning, food preparation using WIC products, budgeting, self-esteem, decision-making and infant feeding. In a county with a low-birth-weight rate of 10.5%, an infant mortality rate of 17.6, and where 26% of all births are to teenagers, the program is designed to improve maternal weight gain, increase birth weights, lower anemia, reduce missed appointments, increase breastfeeding, decrease school dropouts among teenage parents, and cut down on repeat pregnancies among that age group. Once the critical evaluation phase of the project is completed, the educators will be able to serve up to 30% of all pregnant mothers in the county.

HUMPHREYS COUNTY
HEALTH ADVISORS NETWORK

The Humphreys County Health Advisors Network is based on the identification and strengthening of the natural networks of community helping and communication that allow a rural community to survive. Forty-two informal community leaders have completed a 10-week training program covering basic nutrition, health, and community education skills, and are certified by the Health Department to serve as volunteer Community Health Advisors in their neighborhoods, churches and workplaces.

ADVICE
ASSISTANCE
ACTION

Health Advisors provide ~~counseling and sound~~, basic ADVICE, based on their training. They provide ASSISTANCE, Particularly in the form of referrals to appropriate community services and resources. And when a ~~neighborhood or community-wide~~ health issue is encountered, they work with ~~local groups~~ and agencies to organize short and long-term community ACTION efforts to address these problems. They have organized Health Fairs, Clean-up Campaigns, Senior Citizen's events. Early evaluation results show that Health Advisors are currently providing advice and referrals to over 170 families per week through their helping networks. We expect to see in Humphreys County a direct increase in community nutrition and health activities, improved patterns of service utilization, and, over the long haul, fewer high-risk births.

Two things should be stressed. The first is that the Health Advisors are in fact, natural helpers, people who were helping their neighbors long before the P.I.N.A.H. project was conceived, and who will continue to do so long after the project is gone. The intent of the project is to empower their helping, and leave local people with the tools and linkages to further develop their vision for their community. The second is that the Health Department and the other collaborating sponsor agencies have taken a remarkable position on project management. The agencies will provide the initial impetus and support Health Advisor activities, even to the extent of modifying policies and services on the basis of the needs which the Advisors identify. However, the Health Advisors and other local residents will determine the priorities and programs which will be addressed. Rather than playing a supervisor role, the agencies are struggling to learn how to act in partnership with the communities they have been commissioned to serve.

SELF-HELP
PARTNERSHIPS
OUTREACH AND ACCESS

These two projects share three common assumptions. The first is SELF-HELP. Partners for Life stresses individual self-help. The Health Advisors Network emphasizes neighborhood and community self-help. Both projects recognize the essential role that the individual and the community must play in combatting our major killers: heart disease, cancer, accidents, stroke, and infant death.

The second is PARTNERSHIPS, an Inter-Agency approach. The State Health Department and the Cooperative Extension Service are jointly planning, staffing and delivering services through Partners for Life. In Humphreys County, the Health Department is the lead agency, but the Inter-Agency Council is a key local sponsor, helped design and staff the Health Advisor Training Program, and is the legitimizing link between the volunteer health advisors and the professional health care providers and agencies.

Both projects are testing practical ways that OUTREACH and ACCESS can make our own agency programs more effective. Through Partners for Life, WIC provides clinical services and supplementary food, EFNEP provides training in the skills needed to make use of the food and clinical advice. Each program provides what the other lacks, and clients are served on a "one-stop-shopping" basis. The Health Advisors Network provides the outreach the agencies cannot afford to perform, gives the community the access to services it needs and wants, and creates a forum for local dialogue over future public health policy.

COMMUNITY HEALTH PROMOTION
THE CHALLENGE OF THE 90'S

P.I.N.A.H.'s two projects are being evaluated by county residents and collaborating agencies with technical assistance from public health researchers at the University of Alabama at Birmingham and the University of North Carolina, Chapel Hill. While it is too early to interpret final results, early indications are promising: "... the project has successfully recruited the more active and visible members of communities...", "...training is enhancing (Health Advisor) knowledge of health risks and benefits so that they can take appropriate action...", Health Advisors are "...reaching out to individuals through their pre-existing, non-kin social networks...", and "...it appears that the scope of response from Health Advisors is widening in terms of problems and type of support..." *

The P.I.N.A.H. experience in the Delta is a continual learning experience. Low-income pregnant women have a strong desire and capacity to take charge of their lives and raise healthy children. Local participation in planning, implementing and evaluating development efforts is possible, feasible and essential to real and lasting progress. Public agencies and private organizations alike must learn "new ways of doing business" if they are to become truly responsive to local initiatives.

Perhaps the most important lesson to be learned in Leflore and Humphreys County is that Public Health issues do not exist in isolation. Health issues intertwine with poverty, hunger, education, economic and social problems in ways which frustrate abstract and piecemeal solutions. Comprehensive, in-depth responses and lasting solutions will require a tremendous investment in the human resource that is the Delta's rural population. The keys to successful development are not to be found in textbooks - they are waiting to be invented as we risk ourselves in new partnerships with the people of the Delta, partnerships that are dedicated to the vitality and well-being of our neighborhoods and communities.

Submitted by the staff and collaborators of P.I.N.A.H.
P.O.Box 531, Greenwood, MS 38930 (601) 453-1886

* (exerpted from: Dr. Eugenia Eng, "P.I.N.A.H. Evaluation Progress Report: 1988-1989". University of North Carolina, November, 1989.)

Joyce Bowdish, R.N.
 Family & Community
 Health
 State of Iowa
 Des Moines, Iowa

MAMMOGRAM

I am a 47 year old white female. I am a nurse. I have been in good health with hospitalizations only for childbirth and for appendicitis.

I had gone in to have a 6 month check-up as I had had an atypical pap smear. The doctor asked when I'd had my last mammogram. I couldn't remember but knew it was from 3-5 years ago. So an appointment for a mammogram was made for that day. I went and had it done and thought no more about it.

In my job I travel a lot, so when I returned home, I found several messages on my answering machine- each getting more intense- from my gynecologist to call back about the mammogram. I did and was told that there was a spot that I needed to see a surgeon about. I made the appointment as soon as I could fit it into my schedule and his - only about two weeks. I really became very upset, nervous, and agitated. I then kept busy until the Wednesday before the Friday I was to see the surgeon. I became almost immobile with fear but kept on working. Then on Friday, I went in and saw the surgeon who showed me the mammograms. I was shocked to find that I had three spots in my left breast and that on mammogram they had gotten "whiter" in the three years since the last exam.

The doctor tried to aspirate the one that was concerning everyone and could not "hit" it. It was very painful. He scheduled an ultrasound. (I think I was so very upset by then, I didn't know my name.) I had them write down the information for that afternoon so I'd get it straight. Then I returned to work and talked with the supervisor I was working with. She was very understanding and told me to just take the rest of the afternoon off - THANK GOD, I didn't have to "think" anymore!

I went to my appointment. Asked the tech using the machine too many questions. I made it clear I wanted to talk with the doctor who would be reading the ultrasound. He came in, and stated it looked like a cyst, that it was very mobile and would be very difficult to aspirate. He stated that often even using the ultrasound to identify the area of the cyst, (for aspiration) it would take many times before the cyst would be "hit" as it was so mobile. I believe he told me that the cyst was probably benign.

I went to the surgeon's office and said I did not want to make another appointment for aspiration and went home. I collapsed with relief from the tension and high anxiety. I've decided I'd rather have the cyst removed in about six months and I'd like it done by a plastic surgeon. However, none of the 2 that I contacted do that. So now I have another decision or rather some more choices to make. I wanted to talk with my gynecologist but he is out of town for 2 weeks. I'll call back later.

DIABETES

My father was diagnosed as diabetic when he was 34 years old. He continued working against doctor's advise until he was 45. At that time he retired, disabled with multiple complications from his disease. He had become allergic to the insulin necessary to treat his diabetes. He was able to get social security and the family was able to make it with Mom's salary too. Three of my brothers and sisters were still living at home at that time.

Within four years my father was in the terminal phases of his disease. His last year at home he was in the hospital or at the doctor's office every week. His last year alive he lived at the VA hospital in Des Moines, Iowa. He died at the age of 51 leaving Mother to raise two teenagers. Today his life could have been prolonged by renal dialysis though that treatment would have cost upwards of \$23,000.00 per year.

My sister was diagnosed as diabetic when she was 19. She had been in school in Ames, Iowa and was ill enough to be admitted to the intensive care unit in Des Moines. She was there five days before she stabilized enough to be transferred to the wards. She was uninsured. As a student she had too little income to buy insurance, and by leaving home she became ineligible for Mother's coverage, small as it was. Mom and I made payments on her hospital bill for months until we were able to take advantage of Hill Burton monies available for charity write-offs.

My sister remains insulin dependent with ongoing monthly medication expenses for medications and syringes and etc. of about \$112.00. Her ability to work is limited by reduced tolerance and a need to maintain a rigid schedule that does not fit into many work environments. She has been diagnosed for three years, married for two. She wants to have a baby.

My other sister was diagnosed during her third pregnancy. She is diabetic. Because of her unstable medical condition, she had a C-section to deliver the baby early. The costs for her and the baby's hospitalizations were gigantic. She had insurance which paid most of the health care for them both.

Since that time her husband has changed jobs and the new company has hospitalization insurance that will not cover pre-existing conditions. My sister is not covered for any illness, or injury that the insurance company deems related to her diabetes.

I have an abnormal glucose tolerance test. That means that my body does not use the sugar I eat in the same way others do. I am hypothyroid (low thyroid) which is often related to diabetes, and I am classified as a non-insulin dependent diabetic. I am VERY interested in prevention. As a nurse I know the national health care costs for the diabetic population is astronomical. Diabetics are living longer with their disease but as they age they suffer more complications. The most frequent cause of Chronic Renal Failure is Diabetes. Diabetes causes cardiovascular changes and general circulatory problems including cardiac disease, renal failure, and neuropathy (loss of feeling).

Though it is reasonable to expect associations and foundations to fund much of the costs associated with a disease, it is in the public interest for the government to fund research and extensive preventive efforts. Prevention is the diabetic's critical key. I urge the Committee to recognize the importance of preventive education, research and medicine. Our current focus on treatment of illness is growing more and more expensive. This pathological orientation takes ever more of our scarce human resources. It seems clear that the only way to stem the continued rise in health cost is to focus on prevention. The time is now for such a courageous move in health policy directions.

Thank You.

Jane Cameron Schadle R.N.
Des Moines, Iowa

ATTENTION: Senator Tom Harkin

In December of 1984, I attended the Kossuth County Well Elderly Clinic in Whittemore, Iowa for a physical assessment. I had a thorough assessment by the health nurse, Mary Hilbert. Mary found all tests okay, but she suggested that, at my age, it would be a good idea to have further checks, because of common prostate problems. A week later I went to see a urologist and he found an enlarged prostate. He sent a specimen to Iowa City and it was a cancerous tumor.

A second opinion at Mayo Clinic in Rochester, Minnesota confirmed the diagnosed tumor. They suggested surgery and removal of the prostate and testicles. Surgery took place on January 12, 1985. I've had yearly check-ups since and to date all is well.

I feel I've lucked out and I credit our Kossuth County Well Elderly Clinic to which I have returned yearly for check-ups.

Mr. Lawrence Kirsch
707 4th St.
Whittemore, IA 50598
(515) 884-2301

Senator HARKIN. The committee will stand adjourned.
[Whereupon, at 11:55 a.m., the committee was adjourned subject to the call of the Chair.]

○